

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1200

CERTIFICATE OF DEATH

01190

Reg. Dist. No.

337

| | | | | | | | |
|--|------------------------------------|---|--|--|--|--------------------------------------|-------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland | | c. LENGTH OF STAY IN 1b 17 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | d. STREET ADDRESS 20-4002 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Mary | Middle Lee | Last Aimes | 4. DATE OF DEATH Month Jan. | Day 20 | Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH April 9, 1932 | 9. AGE (In years lost birthday) 24 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX | | | 10b. KIND OF BUSINESS OR INDUSTRY XX | 11. BIRTHPLACE (State or foreign country) Exmore, Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME L. Aimes | | | | 14. MOTHER'S MAIDEN NAME Nina Aimes Dare | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown | | 16. SOCIAL SECURITY NO. XX | 17. INFORMANT Hospital Records | Address Salisbury, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia | | | | | | | |
| DUE TO 260X | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kimmelstiel-Wilson syndrome | | | | | | | |
| DUE TO (c) Diabetes mellitus | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 0 | (County) 0 | (State) 0 | |
| 21. I certify that I attended the deceased from Jan. 3, 1957 , to Jan. 20, 1957 , that I last saw the deceased alive on 1/20/57 , and that death occurred at 7:25 P.M. , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) 0 | | | | | | | |
| DATE SIGNED 1/21/57 | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| ACTUAL SIGNATURE S. V. Juerman | | | | | | | |
| M.D. Deer's Head State Hospital | | | | | | | |
| PHYSICIAN'S NAME (Type) V. Juerman | | | | | | | |
| Salisbury, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1-27-57 | 22c. NAME OF CEMETERY OR CREMATORIAL EBENEZER CEMETERY | | 22d. LOCATION (City, town, or county) WARD TOWN, VA. | | |
| (State) 0 | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. STEWART FUNERAL HOME, SALISBURY, MD. | | ADDRESS 0 | | 24a. REC'D BY REGISTRAR MARY HOLLOWAY | 24b. REGISTRAR'S SIGNATURE MARY HOLLOWAY | | |
| DATE 1/28/57 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1201

CERTIFICATE OF DEATH

01191
1. No. 332

Reg. Dist. No.

| | | | | | | | | | | | | | |
|---|--|-------------------------------------|---|---|--|--|---|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | | MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | | b. COUNTY Wicomico | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) | | | c. LENGTH OF STAY IN lb | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | |
| Salisbury | | | 10 Days | | | Eden | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital | | | | | | d. STREET ADDRESS RT.#2 | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) VICTOR | | | First ODELL Middle BANKS | | | 4. DATE OF DEATH Month 1 Day 10 Year 1957 | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 8, 1884 | | 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | |
| 13. FATHER'S NAME Thomas L. Banks | | | | | | 14. MOTHER'S MAIDEN NAME Jennie Murray | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | |
| No. | | | | | | Mrs. Samuel J. Dishroom, Siloan, Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 192x DUE TO <i>Carcinoma left eye.</i> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) DUE TO (c) | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) Salisbury (County) Maryland (State) Md. | | | | |
| 21. I certify that I attended the deceased from 1954 , to 1-10 , 1957, that I last saw the deceased alive on 1-10 , 1957, and that death occurred at 9:30 P.M. from the causes and on the date stated above | | | | | | | | | | | | | |
| ADDRESS (Street, city or town, state) Salisbury, Maryland | | | | | | | | | | | | | |
| DATE SIGNED 1-14-57 | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Philip A. Insley | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Philip A. Insley, 116 East Main St., Salisbury, Maryland | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/13/57 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery | | | 22d. LOCATION (City, town, or county) Fruitland, Maryland | | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Maryland | | | | | | ADDRESS 114-57 | | | 24a. REC'D BY REGISTRAR Mary W. Holloman | | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
must be retained by the hospital or attending physician.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
~~must~~ be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, ~~it~~ it should be filed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BY ZIOMAR RODRIGUES - FROM THE STAFF OF THE BRAZILIAN DAILY JORNAL DA MANHÃ

RECEIVED JAN 17 1954 **BUREAU V. S.**

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01192

1202 CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY WICOMICO | MARYLAND | STATE MARYLAND | COUNTY WORRESTER |
| CITY (If outside corporate limits, write RURAL OR end give nearest town) | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke 23-42-2 | (If rural give location) |
| TOWN SALISBURY | 34 days | STREET ADDRESS 2nd Street | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital | | | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE (Month) (Day) (Year) | |
| Edmond P. | | JANUARY 16 1957 | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH August 27, 1884 |
| 9. AGE last birthday 72 yrs. | 10. KIND OF BUSINESS OR INDUSTRY Bridge Tender | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME McKendlen Bayly | 14. MOTHER'S MAIDEN NAME Ida Pead | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS Stanley Bayly, Pocomoke, Maryland | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X IMMEDIATE CAUSE (A) Cerebral thrombosis ANTECEDENT CAUSE(S) DUE TO (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 420.1 Myocardial Infarct 1 month | | | |
| 18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 2 months | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 12-12, 1956, to 1-16, 1957, that I last saw the deceased alive on 1-16, 1951, and that death occurred at 3:25 P.M., from the causes and on the date stated above. | | | |
| SIGNATURE Willie R. Elliston | M.D. | ADDRESS (Street, city, town, state) Salisbury, Md. | DATE SIGNED 1-17-57 |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-18-57 | NAME OF CEMETERY OR CREMATORIUM Presbyterian Cemetery | LOCATION (City, town, or county) Pocomoke, Maryland |
| 24. REC'D BY REGISTRAR Mary W. Holloway | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson (Pocomoke Md.) | ADDRESS |
| DATE JAN 21 1957 | | | |

WISCONSIN STATE DEPARTMENT OF HIGHEST-MAINTAINING TO

STATE OF WISCONSIN

DEPARTMENT OF

STATE OF WISCONSIN

STATE OF

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6949

CERTIFICATE OF DEATH

08971
337

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|----------------------------------|--|---|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY WICOMICO | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE VIRGINIA | | b. COUNTY ACCOMAC | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY, MD. | | c. LENGTH OF STAY IN 1b 6 MOS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAPPSVILLE, VIRGINIA | | d. STREET ADDRESS — | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING HILL, SALISBURY, MD. | | | | d. STREET ADDRESS — | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 83 X-3 | | | | | | | |
| 3. NAME OF DECEASED (Type or print) JOHN MADISON BLOXOM JR. | | First | Middle | Last | 4. DATE OF DEATH Month JANUARY | Day 8 | Year 1957 |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> | 8. DATE OF BIRTH JAN. 4 1888 | 9. AGE (In years lost birthday) 69 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANT | | 10b. KIND OF BUSINESS OR INDUSTRY STORE | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JOHN MADISON BLOXOM | | 14. MOTHER'S MAIDEN NAME OSHA BUNDICK BLOXOM | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. 1917 | | 17. INFORMANT J.M. BLOXOM III, SALISBURY, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO PARKINSON'S DISEASE | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 MINS. | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7-1 , 19 56 , to 1-8 , 19 57 , that I last saw the deceased alive on 1-8 , 19 57 , and that death occurred at 3 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eugene J. Linberg | | | | | | DATE SIGNED JUNE 18, 1957 | |
| ACTUAL SIGNATURE Eugene J. Linberg | | M.D. MEDICAL CENTER SALISBURY, MARYLAND | | | | | |
| PHYSICIAN'S NAME (Type) EUGENE J. LINBERG | | | | | | | |
| 220. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF JUN 8, 1957 | | 22c. NAME OF CEMETERY OR CREMATORIAL John W. Taylor | | 22d. LOCATION (City, town, or county) (State) TEMPERANCEVILLE, VA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE — | | ADDRESS — | | 24a. REC'D BY REGISTRAR — | | 24b. REGISTRAR'S SIGNATURE — | |
| | | | | DATE JUN 14 1957 | | | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE - BALTIMORE, MD

BUREAU V. S.

AUG 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | |
|---|---|--|--|---|--|--|--------------------------|----------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Ellicott City</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | c. LENGTH OF STAY IN 1b RURAL and give nearest town) | b. COUNTY | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Quinton Road</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Elton</i> | | d. STREET ADDRESS | | | | | | |
| First <i>Bell</i> | Middle <i>Elton</i> | Last <i>Bell, Jr.</i> | 4. DATE OF DEATH <i>Jan. 19, 1957</i> | | | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years lost birthday) <i>59 yrs.</i> | 10. IF UNDER 1 YEAR Months Days Hours Min. <i>1 year</i> | 11. IF UNDER 24 HRS. Hours Min. <i>1 year</i> | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | INFORMANT | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mr. Pancreatitis</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 years</i> | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) | | DUE TO | | | | | | |
| (c) | | DUE TO | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Esophageal Varices</i> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>injury occurred</i> | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i> | | 20f. (City or town) <i>Melfa</i> | (County) <i>Melfa</i> | (State) <i>Virginia</i> |
| 21. I certify that I attended the deceased from <i>March 1955</i> , to <i>Jan. 19, 1957</i> , that I last saw the deceased alive on <i>Jan. 17, 1957</i> , and that death occurred at <i>12:35 P.M.</i> from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) <i>400 E Church St. Melfa, Virginia</i> | | DATE SIGNED <i>Jan. 1, 1960</i> | | |
| ACTUAL SIGNATURE <i>G. Herbert Semly</i> | | M.D. | | | | | | |
| PHYSICIAN'S NAME (Type) <i>G. Herbert Semly</i> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>January 23, 1957</i> | | 22c. NAME OF CEMETERY OR CREMATORIUM <i>Burtons</i> | | 22d. LOCATION (City, town, or county) <i>Melfa, Virginia</i> | | (State) <i>Virginia</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Alfred U. Ames Funeral Home, Melfa, Va.</i> | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <i>FEB 1 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Alfred U. Ames</i> | | |

STATE OF MICHIGAN
ATTORNEY GENERAL

STATE OF MICHIGAN

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01193

337

CERTIFICATE OF DEATH

• 1203

Reg. Dist. No.....

1. PLACE OF DEATHCOUNTY **Wicomico**CITY (If outside corporate limits, write RURAL
OR end give nearest town)TOWN **Salisbury**

MARYLAND

LENGTH OF STAY
(in this place)

3 Years

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

At home - 637 W. Main St.

**3. NAME OF
DECEASED
(Type or Print)****Oscar**

(Middle)

2. USUAL RESIDENCE (HOME) OF DECEASEDSTATE **Salisbury**COUNTY **Wicomico**

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Salisbury**STREET
ADDRESS

(If rural give location)

637 W. Main Street

**4. DATE
OF
DEATH**

(Month) (Day) (Year)

1 - 14 1957

SEX **Male**6. COLOR OR
RACE **A. A.**7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) **Married**

8. DATE OF BIRTH

3-17-1883

9. AGE last birthday

73 yrs.

IF UNDER 1 YEAR

Months 9 Days 27 Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) **Farming**10b. KIND OF BUSINESS
OR INDUSTRY **Self Employed**

11. BIRTHPLACE (State or foreign country)

Gates Co., North Carolina12. CITIZEN OF WHAT
COUNTRY? **U.S.A.**

13. FATHER'S NAME

John Washington Boone

14. MOTHER'S MAIDEN NAME

Unknown15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) **No** (If Yes, give year or dates of service) **No**

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

637 W. Main St.**Miss Harriett Boone, Salisbury, Md.****I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**442x IMMEDIATE CAUSE **(A) Hypertensione Cardiovascular Rand. Disease**

DUE TO

ANTECEDENT CAUSE(S) **(B) Hypertensione & Arteries derosis**
DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. **(C) Indefinite****18. MEDICAL CERTIFICATION**INTERVAL BETWEEN
ONSET AND DEATH**3 months****Indefinite****II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While Not while
al work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from... **14 Oct 1956**, to **18 Jan 1957**, that I last saw the deceasedalive on **18 Jan 1957**, and that death occurred at **12:30 P.M.** from the causes and on the date stated above.SIGNATURE **Hurnell**

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial**1-19-57****Mt. Wesley Cemetery****Snow Hill, Worcester Co. Md.**

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE **JAN 18 1957****Mary H. Holloway****J. F. Stewart Funeral Home, Salisbury, Md.**

BY COMMITTEE OF THE STATES-GENERAL

STATEMENT OF DEATH

BUREAU Y.

JAN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG210 1-29-57 et

01194

335

1251

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | |
|--|--|---|---|--|------------------------------------|---|---|--|---|----------|
| 1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> | | b. COUNTY <i>Wicomico</i> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sharptown</i> | | c. LENGTH OF STAY IN 1b <i>79 yrs.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Sharptown</i> | | d. STREET ADDRESS <i>Main St</i> | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Main</i> | | | | d. STREET ADDRESS <i>Main</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <i>LILLIE</i> | | First | Middle | Last | 4. DATE OF DEATH <i>Bonitas</i> | Month <i>1</i> | Day <i>- 18 -</i> | Year <i>1957</i> | | |
| 5. SEX <i>Female</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>4-25-1878</i> | | 9. AGE (In years last birthday) <i>87 1/2</i> yrs. | 10. IF UNDER 1 YEAR Months <i>0</i> | 11. IF UNDER 24 HRS. Days <i>0</i> | 12. IF UNDER 24 HRS. Hours <i>0</i> | 13. MIN. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at Home</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Sharptown, Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME <i>Isaac Grasenor</i> | | 14. MOTHER'S MOTHER'S NAME <i>Elizabeth Connelly</i> | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT <i>Dr James Bounds-Gafford, Jr.</i> | | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> | | DUE TO <i>Cerebral hemorrhage</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i></i> | | (b) <i>Hypertension</i> | | | | (c) <i>Arteriosclerosis</i> | | | | |
| 4. DUE TO <i></i> | | | | | | | | | | |
| 5. DUE TO <i></i> | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Shapltown</i> | | 20f. (City or town) <i>(County)</i> | | (State) | | |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. S. Kuhlman</i> | | ADDRESS (Street, city or town, state) <i>Sharptown, Md</i> | | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>H. S. Kuhlman</i> | | DATE SIGNED <i>1/19/57</i> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>1-21-1957</i> | | 22c. NAME OF CEMETERY OR Crematory <i>Firemen</i> | | 22d. LOCATION (City, town, or county) <i>Sharptown, Md.</i> | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles W. Marvel</i> | | ADDRESS <i>Sharptown, Md.</i> | | 24a. REC'D BY REGISTRAR <i>JAN 22 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>Mary C. Owens</i> | | | | |
| VS A15 (4) 15M 9/55 | | | | | | | | | | |

WISCONSIN STATE DEPARTMENT OF HEALTH - BIRTHING 18

CERTIFICATE OF DEATH

DEATH

REGISTRATION

NUMBER

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

BUREAU V.

JAN 22 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC F-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01195

1204 CERTIFICATE OF DEATH

Reg. Dist. No. 331

| | | | | | | |
|---|---|--|--|---|---|--|
| 1. PLACE OF DEATH | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | MARYLAND LENGTH OF STAY (in this place) | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | COUNTY STREET ADDRESS | | | |
| Wicomico Salisbury | 9 days | Maryland Sharp Town | Wicomico P.O. Box 133 | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Peninsula General Hospital | | | | | |
| 3. NAME OF DECEASED (First) Charles | (Middle) | (Last) Bradley | 4. DATE (Month) (Day) (Year) OF DEATH JANUARY 26 1957 | | | |
| SEX MALE | COLOR OR RACE White | SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | DATE OF BIRTH 10-1-1893 | AGE last birthday 63 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | | KIND OF BUSINESS OR INDUSTRY Lumber | 11. BIRTHPLACE (State or foreign country) Sharptown | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas J. Bradley | | | 14. MOTHER'S MAIDEN NAME Martha E. Higgins | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes | | 16. SOCIAL SECURITY NO. WWI 217-03-7803 | | 17. INFORMANT & ADDRESS Gen. Ent. 2d Inf. Div., Fort Wayne | | |
| 18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Mesenteric Thrombosis Embolism ANTECEDENT CAUSE(S) DUE TO (B) Coronary decompaction. DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) County: State: | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from 1/17/57, 19....., to 1/26/57, 19....., that I last saw the deceased alive on 1/26/57, 19....., and that death occurred at 12:15 P.M. from the causes and on the date stated above. SIGNATURE: <i>Dr. James L. Cawie</i> ADDRESS: (Street, city, town, state) <i>226 N. Harrison St. Salisbury</i> DATE SIGNED <i>1/26/57</i> | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1-28-1957 | NAME OF CEMETERY OR CREMATORIUM Taylor | LOCATION (City, town, or county) <i>Sharptown, Md</i> (State) <i>Md</i> | | |
| 24. REC'D BY REGISTRAR DATE JAN 31 1957 REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i> ADDRESS <i>Charles W. Matzel, Sharptown, Md</i> | | | | | | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <i>Charles W. Matzel, Sharptown, Md</i> | | | | | | |

BUREAU V.

JAN 31 1957

REFUGIADO

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01196

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS | MARYLAND LENGTH OF STAY (in this place) | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS | COUNTY Worcester ✓ (If rural give location) |
| Wicomico Co. Salisbury Pennysul. Seneca Hospital | MARYLAND 523 Young St. | Pocomoke 2342.2 | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| SEX MALE COLOR | COLOR OR RACE SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | DATE OF BIRTH MARRIED NOV. 2, 1890 | AGE last birthday 66 IF UNDER 1 YEAR Months Deys Hours Min. |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | 10b. KIND OF BUSINESS OR INDUSTRY FISHMAN | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Joseph Butler | | 14. MOTHER'S MAIDEN NAME Lizzie Holland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO | 16. SOCIAL SECURITY NO. 213-01-7213 | 17. INFORMANT & ADDRESS Lebia Butler 523 Young St. Pocomoke Md. | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 454x IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | 18. MEDICAL CERTIFICATION Pulmonary Atelectasis Thrombosis of anterior spinal artery with paraplegia 2 days INTERVAL BETWEEN ONSET AND DEATH minutes | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above. SIGNATURE <i>Edward J. Gelman</i> M.D. ADDRESS (Street, city, town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>1/5/57</i> | | | |
| VS AISC 1-55 10W | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-9-57 | NAME OF CEMETERY OR CREMATORIUM Halls Hill | LOCATION (City, town, or county) Pocomoke Md. |
| 24. REC'D BY REGISTRAR DATE 1-8-57 | REGISTRAR'S SIGNATURE Mary W. Holloway | 25. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va. | |

UNITED STATES GOVERNMENT - MAIL SURVEY

CERTIFICATE OF MAIL

RECEIVED
MAIL SURVEY
MAY 1957

BUREAU Y.

JUN 10 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V.S. AISC 155-10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01197

CERTIFICATE OF DEATH

1206

Reg. Dist. No. 332

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR TOWN give nearest town) | MARYLAND LENGTH OF STAY (in this place) | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN give nearest town) | COUNTY Wicomico |
| Salisbury | 1 wk. | Salisbury | Salisbury |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp. | STREET ADDRESS 711 Ferndale Rd. | | |
| 3. NAME OF DECEASED (First) ANNIE Naylor | | (Middle) COLES | |
| 4. DATE OF DEATH Jan. 1 | | (Year) 1957 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWER, DIVORCED, specify Widowed | 8. DATE OF BIRTH DEC. 31 1869 |
| 9. AGE last birthday 87 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Our Home |
| 11. BIRTHPLACE (State or foreign country) England | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert Naylor | | 14. MOTHER'S MAIDEN NAME MARIA PEMBRYE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT & ADDRESS Mrs. Isabell Ryden - Salisbury | | 18. MEDICAL CERTIFICATION Cardiac arrest. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Cardiac arrest. ANTECEDENT CAUSE(S) DUE TO Pulmonary edema DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO Cerebral Vasculay accident. (C) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan. 1, 1957, to Jan. 1, 1957, that I last saw the deceased alive on Jan. 1, 1957, and that death occurred at 2 P.M. from the causes and on the date stated above. | | | |
| SIGNATURE Andrew Comitchell | | ADDRESS (Street, city, town, state) M.D. 21 Maryland Ave. - Salisbury (State) DATE SIGNED 1/1/57 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1/3/1957 NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery LOCATION (City, town, or county) Salisbury, Md. (State) | |
| 24. REC'D BY REGISTRAR DATE 1-2-56 | | REGISTRAR'S SIGNATURE Mary W. Holloway | |
| 25. FUNERAL DIRECTOR'S SIGNATURE Hill Johnson Co. | | ADDRESS George C. Neely II | |

BUREAU V. 5

JAN 4 1957

REGELIVEO

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01198

331

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | MARYLAND LENGTH OF STAY (In this place) | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | COUNTY Baltimore 3801-4 (If rural give location) |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | 18 days | STREET ADDRESS | 116 N. University Parkway |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| (First) Elsie | (Middle) M. | (Last) Collins | January 11 1957 |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| Female | White | widow | Oct. 30-1872 |
| 9. AGE last birthday yrs. | 10. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| 84 2/11 | own home | Talbot, Md | None |
| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | | |
| William Bond Martin | Rebecca Ecclesby | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | 16. SOCIAL SECURITY NO. | | |
| no | None | | |
| 17. INFORMANT & ADDRESS | | | |
| Mrs Ben J. Truitt, Snow Hill, Md | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 576X IMMEDIATE CAUSE (A) Bronchopneumia | | | |
| ANTECEDENT CAUSE(S) DUE TO Laryngeal peritonitis | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C) | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| | | Laryngeal peritonitis | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 12/24, 1956, to 1/11, 1957, that I last saw the deceased alive on 1/11/57, 1957, and that death occurred at 7:45 P.M., from the causes and on the date stated above. SIGNATURE | | | |
| ADDRESS (Street, city, town, state) | | | |
| DATE SIGNED | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | NAME OF CEMETERY OR CREMATORIUM |
| Burial | | Jan 14/57 | Spring Hill Cemetery |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | LOCATION (City, town, or county) |
| DATE JAN 15 1957 | | Mary W. Holloway | (State) |
| 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| May E. Dennis, Snow Hill, Md | | Md | |

A rectangular stamp with a double-line border. The word "RECEIVED" is stamped vertically along the left edge. Along the top edge, it reads "BUREAU OF INVESTIGATION". In the center, the date "JAN 15 1957" is stamped.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01199
332

Reg. Dist. No.

| | | | | | | | |
|--|---|--|---|--|---|--------------------------|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico Labor Camp | | c. LENGTH OF STAY IN 1b 5 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X R F D # 2 Eden, Md. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Quantico Labor Camp | | | d. STREET ADDRESS R F D # 2 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First Elwood | Middle Filmore | Last Cornish | 4. DATE OF DEATH 1- 28 19 57 | Month | Day | Year |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 1-2-1916 | 9. AGE (in years last birthday) 41 yrs. | IF UNDER 1YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (State or foreign country) Allen, Md. | 12. CITIZEN OF WHAT COUNTRY? U S A | | |
| 13. FATHER'S NAME Daniel F. Cornish | | | 14. MOTHER'S MAIDEN NAME Julia Ann Tull | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Julia Cornish, Box 45, R F D # 2, Eden, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | |
| 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) | (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Royer</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DATE SIGNED 1-29-57 |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1-31-57 | 22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary Cemetery | 22d. LOCATION (City, town, or county) Fruitland, Wicomico, Md. (State) | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. P. Stewart Funeral Home, Salisbury, Md. | | ADDRESS | 24a. REC'D BY REGISTRAR JAN 31 1957 | | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01200

1208 CERTIFICATE OF DEATH

Reg. Dist. No.

33Y

| | | | | | | | |
|--|----------------------------------|---|--|--|-----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 12 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | d. STREET ADDRESS 111 Washington St | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First BEULAH | Middle MAY | Last CUMMINS | 4. DATE OF DEATH JANUARY 13th 1957 | Month Day Year | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH Oct. 17, 1905 | 9. AGE (In years lost birthday) 51 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Operator) | | 10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory | | 11. BIRTHPLACE (State or foreign country) Fitchugh, Ark. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Christopher Columbus Spradlin | | 14. MOTHER'S MAIDEN NAME Lucy Caroline Leslie | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Perry W. Cummins (Husband) 111 Washington St. Salisbury, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | coronary thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr. | |
| | | aortic stenosis | | | | 5 yrs. | |
| | | rheumatic heart disease | | | | 15 yrs. | |
| 20a. MEDICAL CERTIFICATION | | 20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X diabetes mellitus | | | | | |
| 20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20e. TIME OF INJURY Hour a. m. p. m. | | 20f. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20g. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. Maryland Ave. (Office) | | (County) Maryland | (State) Salisbury, Maryland |
| 21. I certify that I attended the deceased from _____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE Carl W. Spradlin | | ADDRESS (Street, city or town, state) DATE SIGNED Jan. 14, 1957 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 15, 1957 | | 22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park | | 22d. LOCATION (City, town, or county) Salisbury, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | ADDRESS JAN 15 1957 | | 24a. REC'D BY REGISTRAR Mary W. Holloway | | 24b. REGISTRAR'S SIGNATURE | |
| VS A15 (4) 15M 9/55 | | | | | | | |

RECEIVED JAN 15 1957 **BUREAU V. S.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01201

Reg. Dist. No.

337

1253

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Snow Hill Rural #2

c. LENGTH OF STAY IN 1b

4 mo

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

None

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

MD

b. COUNTY

Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

XO Snow Hill

Rural #2

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month
1

Day
18

Year
1957

5. SEX

6. COLOR OR RACE

M

Iceland

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Sept. 9, 1956

9. AGE (In years
last birthday)

yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

✓

11. BIRTHPLACE (State or foreign country)

Salisbury, MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Walter James Dale

14. MOTHER'S MAIDEN NAME

Bertie Nellie Baine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
70

16. SOCIAL SECURITY NO.

701-12-1212

17. INFORMANT

Walter J. Dale

Address

Rural #2

INTERVAL BETWEEN
ONSET AND DEATH

24 hours

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Lobar pneumonia

490X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m.
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Earl L. Rover, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

1-18-57

22a. BURIAL CREMATION, DATE THEREOF
REMOVAL (Specify)

22b. NAME OF CEMETERY OR CREMATORIUM

22c. LOCATION (City, town, or county)

(State)

22d. REC'D BY REGISTRAR

DATE

22e. REGISTRAR'S SIGNATURE

DATE

22f. REGISTRAR'S SIGNATURE

DATE

22g. REGISTRAR'S SIGNATURE

DATE

22h. REGISTRAR'S SIGNATURE

DATE

22i. REGISTRAR'S SIGNATURE

DATE

22j. REGISTRAR'S SIGNATURE

DATE

22k. REGISTRAR'S SIGNATURE

DATE

22l. REGISTRAR'S SIGNATURE

DATE

22m. REGISTRAR'S SIGNATURE

DATE

22n. REGISTRAR'S SIGNATURE

DATE

22o. REGISTRAR'S SIGNATURE

DATE

22p. REGISTRAR'S SIGNATURE

DATE

22q. REGISTRAR'S SIGNATURE

DATE

22r. REGISTRAR'S SIGNATURE

DATE

22s. REGISTRAR'S SIGNATURE

DATE

22t. REGISTRAR'S SIGNATURE

DATE

22u. REGISTRAR'S SIGNATURE

DATE

22v. REGISTRAR'S SIGNATURE

DATE

22w. REGISTRAR'S SIGNATURE

DATE

22x. REGISTRAR'S SIGNATURE

DATE

22y. REGISTRAR'S SIGNATURE

DATE

22z. REGISTRAR'S SIGNATURE

DATE

22aa. REGISTRAR'S SIGNATURE

DATE

22bb. REGISTRAR'S SIGNATURE

DATE

22cc. REGISTRAR'S SIGNATURE

DATE

22dd. REGISTRAR'S SIGNATURE

DATE

22ee. REGISTRAR'S SIGNATURE

DATE

22ff. REGISTRAR'S SIGNATURE

DATE

22gg. REGISTRAR'S SIGNATURE

DATE

22hh. REGISTRAR'S SIGNATURE

DATE

22ii. REGISTRAR'S SIGNATURE

DATE

22jj. REGISTRAR'S SIGNATURE

DATE

22kk. REGISTRAR'S SIGNATURE

DATE

22ll. REGISTRAR'S SIGNATURE

DATE

22mm. REGISTRAR'S SIGNATURE

DATE

22nn. REGISTRAR'S SIGNATURE

DATE

22oo. REGISTRAR'S SIGNATURE

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DATE

22uu. REGISTRAR'S SIGNATURE

DATE

22vv. REGISTRAR'S SIGNATURE

Biological Exchange and Detrital Flow

JAN 22 1957

RECEIVE

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01202

33Y

1209 CERTIFICATE OF DEATH

Reg. Dist. No. 297

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN | MARYLAND LENGTH OF STAY (in this place) | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | COUNTY Delemer (If rural give location) |
| Salisbury Peninsula General Hospital | | XO STREET ADDRESS | 503 Elizabeth Street |
| 3. NAME OF DECEASED (Type or Print) | (First) Sallie | (Middle) Dashrell | (Last) |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH July 23 1867 |
| 9. AGE last birthday 89 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | 11. BIRTHPLACE (State or foreign country) Somera Delaware |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | 13. FATHER'S NAME Ludlow Sutliss | 14. MOTHER'S MAIDEN NAME Susan Anne Holding | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS Family/Rev. Paul Williams | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 155X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | Coronary thrombosis Arteriosclerosis generalized Carcinoma gall bladder | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above. SIGNATURE: <i>Willie H. Fisher</i> M.D. ADDRESS (Street, city, town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>12/22/57</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | DATE THEREOF 1/22/57 | NAME OF CEMETERY OR CREMATORIUM <i>Christ Church Cemetery St. Michael's</i> | LOCATION (City, town, or county) <i>St. Michael's</i> (State) <i>Ind</i> |
| 24. REC'D BY REGISTRAR DATE <i>Jan 22, 57</i> | REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>S. Hambleton Harrison, St. Michael's</i> | |

RECEIVED - COMMUNICATIONS SECTION - STATE DEPARTMENT

CERTIFICATE OF DELIVERY

OMNI-TELE
NO. 1000
1957

52 10/25/57

Mr. John F. Kennedy
President and Mrs.
John F. Kennedy

10/25/57

BUREAU V. A.

10/23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01203

1210

CERTIFICATE OF DEATH

Reg. Dist. No.

337

| | | | | |
|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 12 | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 Buena Vista Ave | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First ARRA | Middle JANE | Last DAVIS | |
| 4. DATE OF DEATH | Month JAN. | Day 4 th | Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH June 13, 1891 | |
| 8. AGE (In years lost birthday) 65 yrs. | 9. IF UNDER 1 YEAR Months 0 | 10. IF UNDER 24 HRS. Days 0 | 11. Hours 0 | 12. Minutes 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Pocomoke, Maryland |
| 13. FATHER'S NAME Benjamin Morgan | | 14. MOTHER'S MAIDEN NAME Elizabeth Smith | | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Lydia Campbell (Daughter) |
| | | | | Address 304 Buena Vista Ave. Salisbury, Maryland |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Wremia | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Carcinoma Liver | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Salisbury (County) Wicomico (State) Maryland |
| 21. I certify that I attended the deceased from 9-1, 1956 , to 1-4, 1957 , that I last saw the deceased alive on 1-3, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Center DATE SIGNED Jan. 5 1957 | | | | |
| ACTUAL SIGNATURE Wm. B. Smith | | PHYSICIAN'S NAME (Type) Dr. William B. Smith M.D. Salisbury, Maryland | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 6, 1957 | 22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park | 22d. LOCATION (City, town, or county) Salisbury, Maryland v (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | ADDRESS 1200 | 24a. REC'D BY REGISTRAR JAN 8 1957 | 24b. REGISTRAR'S SIGNATURE Mary W. Holloway |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 2908774-12AFC TSIATTAQ STATE OWNERS

BUREAU V.

JAN 8 1957

KEGEIV EO

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01204

1211 CERTIFICATE OF DEATH

Item 7 Film G209 1-10-57 et

Reg. Dist. No. 332

1. PLACE OF DEATH

COUNTY WicomicoCITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN SalisburyHOSPITAL OR
INSTITUTION OR
STREET ADDRESSPeninsula General Hospital

MARYLAND

LENGTH OF STAY
(In this place)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE 83x Virginia

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWNSTREET
ADDRESSCOUNTY AccomacChincoteague, VirginiaNorth Main St.3. NAME OF
DECEASED
(Type or Print)(First) Lizzie

(Middle)

(Last)

4. DATE (Month) (Day) (Year)
OF DEATH Jan. 3 1957

</

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01205

332

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>Salisbury</u> | | MARYLAND LENGTH OF STAY (in this place) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL end give nearest town) OR TOWN <u>Pittsville, Md.</u> STREET ADDRESS <u>XO 1</u> RFD | |
| 3. NAME OF DECEASED (Type or Print) <u>George</u> | | (First) <u>Dennis</u> (Middle) <u>Dennis</u> (Last) | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Aug. 12, 1891</u> |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken raiser</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Filmore Dennis</u> | 14. MOTHER'S MAIDEN NAME <u>Sallie Scott</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>X</u> | 16. SOCIAL SECURITY NO. <u>220-12-1746</u> | 17. INFORMANT & ADDRESS <u>Mrs Myra Dennis Pittsville, Md.</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>332X</u> IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO _____ STATING UNDERLYING CAUSE LAST. (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) <u>Salisbury, Md.</u> (State) <u>MD</u> | |
| 21d. TIME OF INJURY (Month) <u>12</u> (Day) <u>28</u> (Year) <u>1954</u> (Hour) <u>4 P.M.</u> | 21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from.....12-28, 1954, to.....1-2, 1957, that I last saw the deceased alive on.....1-2, 1957, and that death occurred at.....4 P.M., from the causes and on the date stated above. | | | |
| SIGNATURE <u>Wiley R. Ellis</u> M.D. ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>1-2-57</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | DATE THEREOF <u>1/5/58</u> | NAME OF CEMETERY OR CREMATORIAL <u>New Hope</u> | LOCATION (City, town, or county) <u>Willards</u> (State) <u>Md.</u> |
| 24. REC'D BY REGISTRAR DATE <u>JAN 2 1957</u> | REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u> ADDRESS <u>Hallayell Rd.</u> | |

STATE OF TEXAS
DEPARTMENT OF PUBLIC SAFETY

CERTIFICATE OF DEATH

100-1000000

100-1000000

BUREAU V. A.

JAN 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1213

CERTIFICATE OF DEATH

01206

Reg. Dist. No.

330

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 20 yrs | |
| d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. STREET ADDRESS 12 Salisbury | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 611 Camden Ave. | | d. DATE OF DEATH 1 20 1957 | |
| 3. NAME OF DECEASED (Type or print) ELLA MAY CONLEY | First ELLA | Middle MAY | Last CONLEY |
| S. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH December 13, 1879 |
| 8. KIND OF BUSINESS OR INDUSTRY House Wife | | 9. AGE (In years last birthday) 77 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John W. Covington | |
| 14. MOTHER'S MAIDEN NAME Laura E. Robinson | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Mrs. Wm. H.J. White | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X | | INTERVAL BETWEEN ONSET AND DEATH Cerebral accident | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) | | DUE TO Carcinoma (Probable Metastasis) | |
| DUE TO (c) "Breast" | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-1 , 19 57 , to 1-20 , 19 57 , that I last saw the deceased alive on 1-19 , 19 57 , and that death occurred at 6a M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. B. Smith | | ADDRESS (Street, city or town, state) DR. WILLIAM B. SMITH The Medical Center Rt. 1, Salisbury, Md. | |
| PHYSICIAN'S NAME (Type) William Smith | | DATE SIGNED 1/21/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1/22/1957 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park | | 22d. LOCATION (City, town, or county) Salisbury, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. | | ADDRESS Salisbury, Maryland | |
| 24a. REC'D BY REGISTRAR 1-20-57 | | 24b. REGISTRAR'S SIGNATURE Mary W. Holloway | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANHATTAN STATE PENITENTIARY OF NEW YORK - GARDNERS IS.

CERTIFICATE OF DEATH

BUREAU V. S
RECEIVED
JAN 23 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1214

CERTIFICATE OF DEATH

01207
337

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b XO | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | e. STREET ADDRESS Pittsville | | | |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) MAGGIE | | First ELIZABETH | Middle DONOWAY | | |
| Last 18th 1957 | | 4. DATE OF DEATH JANUARY | Month Day Year | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 11, 1878 | | |
| 9. AGE (In years last birthday) 78 | | 10. IF UNDER 1 YEAR Months 1 Days 0 | 11. IF UNDER 24 HRS. Hours 0 Min. 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Gumboro, Delaware | | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | |
| 13. FATHER'S NAME Edward Hitchens | | 14. MOTHER'S MAIDEN NAME Mary Hester Truitt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mr. Thomas C. Donoway (Husband) Pittsville, Maryland Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | Coronary Artery Thrombosis INTERVAL BETWEEN ONSET AND DEATH 3 days Coronary Atherosclerosis 1 yr | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Insufficiency | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | |
| 20c. TIME OF INJURY Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) Pittsville Carroll Maryland (State) | |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE David Gilmore Jr. M.D. Medical Center (Office) Jan. 19 1957 PHYSICIAN'S NAME (Type) Dr. Wilber Ellis M.D. Dr. David Gilmore M.D. Salisbury, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 20, 1957 | 22c. NAME OF CEMETERY OR CREMATORIUM Pittsville Cemetery | 22d. LOCATION (City, town, or county) Pittsville, Maryland (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | 24a. REC'D BY REGISTRAR AN 21 1957 | 24b. REGISTRAR'S SIGNATURE Mary W. Holloway | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 21 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01208

334

1215 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATHCOUNTY **Wicomico**CITY (If outside corporate limits, write RURAL
OR end give nearest town)TOWN **Salisbury****MARYLAND**LENGTH OF STAY
(in this place)

6 Wks.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS**Riverside Convalescent Home****2. USUAL RESIDENCE (HOME) OF DECEASED**STATE **Maryland**COUNTY **Wicomico**

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **XO Waterview, Maryland**STREET
ADDRESS
(If rural give location)**3. NAME OF
DECEASED
(Type or Print)**(First) **Rebecca** (Middle) **Amelia** (Last) **Dunn**S. SEX **F**6. COLOR OR
RACE **White**7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) **Widowed**8. DATE OF BIRTH **Oct. 14, 1862**10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) **Housewife**10b. KIND OF BUSINESS
OR INDUSTRY **Own Home**

11. BIRTHPLACE (State or foreign country)

Maryland9. AGE last birthday **94** yrs. **3** months **3** days **19 57** hours **Min.**12. CITIZEN OF WHAT
COUNTRY? **US**13. FATHER'S NAME **Joseph Jiles**14. MOTHER'S MAIDEN NAME **Sarah Horner**15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) **No** (If Yes, give war or dates of service)16. SOCIAL SECURITY NO. **-----**

17. INFORMANT & ADDRESS

Elbert Dunn, Waterview, Md.**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH****420.0 IMMEDIATE CAUSE**ANTECEDENT CAUSE(S) DUE TO **(A) Arteriosclerotic Heart Disease**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE **(B)**STATING UNDERLYING CAUSE LAST. DUE TO **(C)****II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**19e. DATE OF OPERATION **-----**19b. MAJOR FINDINGS OF OPERATION **Cerebral Decompensation**INTERVAL BETWEEN
ONSET AND DEATH**10 Years****3 days**

20. AUTOPSY?

YES NO

VS A15C-55 10W

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,

OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

M. at work et work

MASSACHUSETTS STATE DEPARTMENT OF MILITARY AFFAIRS

CERTIFICATE OF DELIVERY

BUREAU V. 2

JAN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG210 1-29-57 et

01209

CERTIFICATE OF DEATH

Reg. Dist. No.

1254

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Marlboro Springs

c. LENGTH OF STAY IN lb

3 wks,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Maple Shade Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Pennsylvania

b. COUNTY

Philadelphia

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

75X-3 Philadelphia

d. STREET ADDRESS

5702 Hadfield St.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
IDAMiddle
MAYLast
ELLIOTT4. DATE
OF
DEATHMonth
1Day
20Year
19 57

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

November 13, 1876

9. AGE (In years
last birthday)

80 yrs.

IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Henry Propert

14. MOTHER'S MAIDEN NAME

Margaret E. Simon

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Mrs. Herbert Schaab

Address

Salisbury, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

491X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost. (b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

4 day

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. 1920d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from January 16, 1957, to June 20, 1957, that I last saw the deceased alive on January 20, 1957, and that death occurred at M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

ACTUAL
SIGNATURE

H. S. Kuhlman

M.D.

Sharptown Md

DATE SIGNED
1/21/57PHYSICIAN'S
NAME (Type)

H. S. Kuhlman

22a. BURIAL, CREMATION,
REMAINS (Specify)

1/23/1957

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

West Laurel Hill Cemetery

22d. LOCATION (City, town, or county)

Philadelphia, Pennsylvania
(State)

23. FUNERAL DIRECTOR'S SIGNATURE

The Hill & Johnson Co.

ADDRESS

Salisbury, Maryland

24a. REC'D BY REGISTRAR

DATE 1/21/57

24b. REGISTRAR'S SIGNATURE

Mary C. Owens

MANHATTAN STATE DEVELOPMENT CORPORATION
CERTIFICATE OF DATA

BUREAU A. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 332

01210

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Salisbury | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. # 3 (Delmar Rd) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First RALPH | Middle EVERETT | Last EVANS |
| 4. DATE OF DEATH | Month January | Day 4 | Year th 1957 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH February 5, 1891 |
| | | | 9. AGE (In years last birthday) 65 yrs. |
| | | | IF UNDER 1 YEAR Months 10 Days 29 |
| | | | IF UNDER 24 HRS. Hours 29 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Meat) | | 10b. KIND OF BUSINESS OR INDUSTRY Supply House | |
| 11. BIRTHPLACE (State or foreign country) Salisbury Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME John W. Evans | | 14. MOTHER'S MAIDEN NAME Julia E. Evans | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs. no. or unknown) Unk | | 16. SOCIAL SECURITY NO. | |
| | | 17. INFORMANT Mr. Samuel J. Evans (Brother) Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerosis cerebral | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hyperthyroidism, arteriosclerotic heart disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Heart disease | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>L. V. Sohler</i> | | ADDRESS (Street, city or town, state) M.D. 303 East St. (Office) Jan. 5 1957 DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan. 7, 1957 | 22c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery | 22d. LOCATION (City, town, or county) Salisbury, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | ADDRESS 15M 9/55 | 24a. REC'D BY REGISTRAR DATE JAN 8 1957 | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway |

CERTIFICATE OF DEATH

Date of Birth

Name of Deceased

Cause of Death

BUREAU V.

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1256

CERTIFICATE OF DEATH

Reg. Dist. No.

0121337

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|---------------------------------|---|--|--|--|--|-------------------|-------------------------------|--------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Salisbury | | c. LENGTH OF STAY IN 1b 12 years | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Mt. Herman Rd. Rt. # 3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Sarah | | First Eliza | Middle Fisher | | | | | | |
| 4. DATE OF DEATH 1 - 21 - 1957 | Month | Day | Year | | | | | | |
| 5. SEX Female | 6. COLOR OR RACE A.A. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1886 | 9. AGE (In years last birthday) 70 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Housework | | 11. BIRTHPLACE (State or foreign country) Accomac County, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Frank Young | | | 14. MOTHER'S MAIDEN NAME Lettie Susan Savage | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Rosie Bowen, Salisbury, Md. Route # 3 | | AMOUNT: Herman Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO essential hypertension INTERVAL BETWEEN ONSET AND DEATH 6 mos. | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) essential hypertension DUE TO 5 yrs. (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Salisbury | | (County) Worcester Co. | (State) Md. |
| 21. I certify that I attended the deceased from Aug 1957 , to 1/21 1957 , that I last saw the deceased alive on 1/20 1957 , and that death occurred at 6 A.M. from the causes and on the date stated above. | | | | | | | | | |
| ACTUAL SIGNATURE Parley Bowditch ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 1-23-57 | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-27-57 | | 22c. NAME OF CEMETERY OR CREMATORIUM St. James Cemetery | | 22d. LOCATION (City, town, or county) Nr. Snow Hill, Worcester Co. Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md. | | | | | 24a. REC'D BY REGISTRAR DATE JAN 24 1957 | | | | |
| | | | | | 24b. REGISTRAR'S SIGNATURE DATE Mary J. Holloway | | | | |

CERTIFICATE OF DEATH

| | | | | | |
|--|-------------|-----|-----|--------------|----------------|
| REGISTRATION NO. | NAME | SEX | AGE | DEATH DATE | CAUSE OF DEATH |
| 100-12345678 | JOHN D. DOE | M | 55 | JAN 24, 1957 | HEART DISEASE |
| DECEASED LIVED AT: 1234 FAIRFIELD DR., MILWAUKEE, WI 53215 | | | | | |
| BUREAU V. 4 | | | | | |
| JAN 24 1957 | | | | | |
| RECEIVED | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01212

332

CERTIFICATE OF DEATH

Reg. Dist. No.

M

| | | | | |
|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland | | c. LENGTH OF STAY IN 1b 8 Years | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fruitland General Delivery | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Wicomico | | |
| 3. NAME OF DECEASED (Type or print) | First Mary | Middle Louise | Last Floyd | |
| 4. DATE OF DEATH | Month 1 | Day 13 | Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 4, 1884 | |
| 9. AGE (In years last birthday) 72 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | 12. IF UNDER 24 HRS. Hours 0 | |
| 13. FATHER'S NAME Azariah Griffin | 14. MOTHER'S MAIDEN NAME Mary Black | 15. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 16. SOCIAL SECURITY NO. 217-01-8093 | 17. INFORMANT Mrs. Mary E. Ball | Address Fruitland, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. coronary artery occlusion INTERVAL BETWEEN ONSET AND DEATH 1 week | | | | |
| b) arteriosclerosis, coronary and general 1 week | | | | |
| c) Anemia, severe - cause undetermined ? | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Delmar | (County) Md. (State) 1-15-57 |
| 21. I certify that I attended the deceased from Jan 4th, 1957 to Jan 13th, 1957 that I last saw the deceased alive on Jan 10th, 1957 , and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar, Md. DATE SIGNED 1-15-57 | | | | |
| ACTUAL SIGNATURE <i>L.V. SOHLER</i> | PHYSICIAN'S NAME (Type) L.V. SOHLER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan. 16, 1957 | 22c. NAME OF CEMETERY OR CREMATORIUM Easton Cemetery | 22d. LOCATION (City, town, or county) Easton | (State) Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Gradsaw & Sons - Crisfield, Md.</i> | ADDRESS | 24a. REC'D BY REGISTRAR E-19-57 | 24b. REGISTRAR'S SIGNATURE Mary W. Holloman | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 390M140-401A87FC 7834774930 91472 CRA017460

BUREAU V. S.

JAN 22 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01213
332

| | | | | | | | | | |
|--|----------------------------------|--|---|--|--|--|----------------------------|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 12 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | d. STREET ADDRESS 12 207 Broad St | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First FLOSSIE | Middle DALE | Last GIVAN | 4. DATE OF DEATH | Month JANUARY | Day 25th | Year 19 57 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH July 31, 1886 | 9. AGE (In years last birthday) 70 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen House Work | | 10b. KIND OF BUSINESS OR INDUSTRY at own Home | | 11. BIRTHPLACE (State or foreign country) Gumboro, Delaware | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Louder Theo. Hearne | | | | 14. MOTHER'S MAIDEN NAME Fannie Homans | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Miss Misie Hearne (Sister) 207 Broad St. Salisbury, Maryland | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Doy 19 | 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) E. Main St. (Office) | (County) Salisbury | (State) Maryland | | |
| 21. I certify that I attended the deceased from 1-23-1957 to 1-25-1957 , that I last saw the deceased alive on 1-23-1957 , and that death occurred at 10:25A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jan. 25 1957 | | | | | | | | | |
| ACTUAL SIGNATURE Philip A. Insley | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Philip A. Insley M.D. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 28, 1957 | | 22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery | | 22d. LOCATION (City, town, or county) Salisbury, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | | | | | | | | |
| 24a. REC'D. BY REGISTRAR DATE JAN 29 1957 | | | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE Mary J. Holloway | | | | | | | | | |

CERTIFICATE OF DEATH

DEATH CERTIFICATE

100

NAME

AGE

100

NAME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01214

1258

CERTIFICATE OF DEATH

Reg. Dist. No.

331

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs | | c. LENGTH OF STAY IN 1b 12 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ----- | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Norris | Middle Edward | Last Good |
| 4. DATE OF DEATH | Month Jan. | Day 4th | Year 1957 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 23, 1956 |
| 9. AGE (In years lost birthday) yrs. 12 | 10. IF UNDER 1 YEAR Months 12 | 11. IF UNDER 24 HRS. Days 0 | 12. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (State or foreign country) Salisbury, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | Address | |
| 13. FATHER'S NAME Douglas Good | | 14. MOTHER'S MAIDEN NAME Silvie Gean Massey | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Douglas Good, Mardela Springs, Md. | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 75H.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) | | | |
| <i>Congenital Heart Disease</i> <i>type unknown</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH Since birth | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from birth , 19 56 , to 1957 , that I last saw the deceased alive on Dec 22, 1956 , and that death occurred at Mardela Springs , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Ernest M. Lamm</i> | | ADDRESS (Street, city or town, state) Delaware Del | |
| PHYSICIAN'S NAME (Type) E. M. Lammone | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1-6-1957 | 22c. NAME OF CEMETERY-CREMATORIUM Mardela | 22d. LOCATION (City, town, or county) (State) Mardela Springs, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Powell Shapton, Jr. | | 24a. REC'D BY REGISTRAR DATE JAN 9 1957 | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway |
| 24. ADDRESS 20821928746 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGULATING STATE OF NEW YORK - BUREAU 18

CERTIFICATE OF DELIVERY

BUREAU Y.

JAN 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11215
332

1217

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

| | | | | | | | | |
|--|----------------------------|---|---|---|---------------------------------------|---|----------------------------|--|
| 1. PLACE OF DEATH o. COUNTY | Wicomico MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | o. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | Salisbury | | | c. LENGTH OF STAY IN 1b | 4 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | Peninsula General Hospital | | | d. STREET ADDRESS | 23x22 | | | |
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | |
| | Nora | V. | Goswellen | 11-30-1871 | 1 | 3 | 19 57 | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | | |
| F | W | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 11-30-1871 | 85 yrs. | Months | Days | Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | |
| Housewife | | | | | | Maryland | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Edward Dryden | | | Mary Francis Long | | | USA | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| | | | None | | | Mrs G. Randall Mason, Pocomoke City, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | | | |
| 332 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio-sclerosis Years | | | | | | | | |
| DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | |
| Fracture of right hip YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient slipped and fell at home while washing dishes. | | | | | |
| 20c. TIME OF INJURY Hour | | Month, Day, Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 12 noon | | 12-31-1956 | Home | Pocomoke | Worcester | Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Rover</i> | | | DATE SIGNED 1-4-57 | | | | | |
| EXAMINER'S NAME (Type) Earl L. Rover, M.D. | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORIUM | | | 22d. LOCATION (City, town, or county) (State) | | |
| Burial | | 1-6-57 | Stockton M.E. Cemetery | | | Stockton, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry J. Watson</i> | | | ADDRESS | | | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE | |
| | | | Pocomoke, Md. | | | DATE 1-8-1957 | Mary H. Holloway | |

RECEIVED EXAMINER'S CERTIFICATE OF DEATH
MAY 1958 - DEPARTMENT OF JUSTICE

BUREAU V. S.

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1218

CERTIFICATE OF DEATH

Reg. Dist. No.

11216
321✓

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Fugue 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|--|------------------------------|---|---|--|----------------------|----------------|
| 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 3 yr. 10 mo. | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton 20-42-2 | | | | |
| 3. NAME OF DECEASED (Type or print) Elmer | | Middle J | 4. DATE OF DEATH Jan. 7, 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | B. DATE OF BIRTH 5/21/1892 | | | |
| 8. AGE (In years lost birthday) 64 yrs. | | 9. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY -- | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 13. FATHER'S NAME John Harris | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. | | 16. SOCIAL SECURITY NO. -- | 17. INFORMANT Address Hospital Records, Deer's Head, Salisbury, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction INTERVAL BETWEEN ONSET AND DEATH 30 min. 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic heart disease ? (c) | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Recurrent cerebral thrombosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Hour o. s. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Salisbury | (County) Maryland | (State) Md. |
| 21. I certify that I attended the deceased from March 3, 1953, to Jan. 7, 1957, that I last saw the deceased alive on Jan. 7, 1957, and that death occurred at 10:20 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 1/8/57 | | | | | | |
| ACTUAL SIGNATURE Dr. V. Juerman. | M.D. | | | | | |
| PHYSICIAN'S NAME (Type) V. Juerman, M. D. | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1/12/57 | 22c. NAME OF CEMETERY OR CREMATORIUM New Chapel Cem. | 22d. LOCATION (City, town, or county) Easton, Md. (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James B. Hashell, Easton, Md. | | ADDRESS | 24a. REC'D BY REGISTRAR 1/13/57 | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | DATE | |

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 14 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS AISC 1-55 10K

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01217

CERTIFICATE OF DEATH

1219

Reg. Dist. No. 337

1. PLACE OF DEATH

COUNTY Wicomico
 CITY (If outside corporate limits, write RURAL
OR and give nearest town)
 TOWN Salisbury

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Peninsula General Hospital

MARYLAND

LENGTH OF STAY
(in this place)

2 days

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Wicomico
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN Seaford

STREET
ADDRESS

(If rural give location)

State

**3. NAME OF
DECEASED
(Type or Print)**

(First) Harvey (Middle) WILBUR (Last) Hastings

**4. DATE (Month)
OF
DEATH**

(Day) (Year)

SEX Male COLOR OR
RACE white

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) Farmer

10b. KIND OF BUSINESS
OR INDUSTRY Farm

5. SEX**6. COLOR OR
RACE****7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)****8. DATE OF BIRTH****9. AGE last birthday****10. IF UNDER 1 YEAR****11. IF UNDER 24 HRS.****Months****Days****Hours****Min.****12. CITIZEN OF WHAT
COUNTRY?****13. FATHER'S NAME****14. MOTHER'S MAIDEN NAME****15. WAS DECEASED EVER IN U. S. ARMED FORCES?****16. BIRTHPLACE (State or foreign country)****17. INFORMANT & ADDRESS****18. MEDICAL CERTIFICATION****19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH****20. INTERVAL BETWEEN
ONSET AND DEATH**

334X IMMEDIATE CAUSE (A) Cerebral Arteriosclerosis

ANTECEDENT CAUSE(S) DUE TO (B) Pulmonary Emphysema
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
 STATING UNDERLYING CAUSE LAST. DUE TO (C)

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**

YES NO

21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

M. While at work Not while at work

21a. INJURY OCCURRED

M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-31, 1957, to 1-2, 1957, that I last saw the deceased

alive on 1-2, 1957, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

1-4-1957

NAME OF CEMETERY OR CREMATORIUM

Mt Olive

LOCATION (City, town, or county)

Seaford Del

(State)

24. REC'D BY REGISTRAR

DATE 1-7 1957

REGISTRAR'S SIGNATURE

Mary J. Holloway

25. FUNERAL DIRECTOR'S SIGNATURE

W.S. Mason Co. Seaford, Del

ADDRESS

RECEIVED IN THE LIBRARY OF THE STATE OF ILLINOIS

STATE LIBRARIES

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

JAN 7 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9, Film G210, 2/8/57 bh

CERTIFICATE OF DEATH

1259

01218
33Y

Reg. Dist. No.

| | | | | | |
|---|------------------------------|---|---|---|--|
| 1. PLACE OF DEATH | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | Wicomico Tyaskin | MARYLAND LENGTH OF STAY (in this place) Lifetime | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | Maryland Tyaskin | COUNTY Wicomico (If rural give location) |
| | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | 4. DATE OF DEATH | | |
| (First) Minnie Riall Hopkins | | | Jan. 23 1957 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH Oct. 2, 1878 | 9. AGE last birthday 79 78 yrs. | IF UNDER 1 YEAR Months 3 Days 21 Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Albert Riall | | | 14. MOTHER'S MAIDEN NAME Martha Davis Riall | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | | 16. SOCIAL SECURITY NO. ----- | | |
| 17. INFORMANT & ADDRESS Earl Hopkins, Tyaskin, Maryland | | | 18. MEDICAL CERTIFICATION | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerosis Generalized</u> DISEASES OR CONDITIONS, IF ANY, (B) <u>Diabetes Mellitus</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>10 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION | | | 19b. MAJOR FINDINGS OF OPERATION | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) | | | (State) | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/> | | |
| | | | 21f. HOW DID INJURY OCCUR? | | |
| 22. I hereby certify that I attended the deceased from <u>2/18, 1955</u> , to <u>1/23, 1957</u> , that I last saw the deceased alive on <u>1/23, 1957</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Richard H. Sorendsen</u> M.D. ADDRESS (Street, city, town, state) <u>New Market Rd.</u> DATE SIGNED <u>1/25/57</u> | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | DATE THEREOF <u>1/26/57</u> NAME OF CEMETERY OR CREMATORIUM <u>Saint Marys Cemetery</u> LOCATION (City, town, or county) <u>Tyaskin, Maryland</u> (State) | | |
| 24. REC'D BY REGISTRAR DATE <u>EEB 4 1957</u> | | | REGISTRAR'S SIGNATURE <u>Mary H. Holloway, C.P. Messier</u> FUNERAL DIRECTOR'S SIGNATURE <u>Bivalve, Maryland</u> ADDRESS | | |

WISCONSIN STATE QUADRANT - MARCH 1957

CERTIFICATE OF DEATH

BUREAU V.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. *01219 332*

| | | | | | | | | | | | |
|---|----------------------------------|---|--|--|--|---|--|--|---------|-------------|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b Allen | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | e. STREET ADDRESS R.D.# (Box# 194) | | f. DATE OF DEATH Jan. 26th | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) NELLIE | | First NELLIE | Middle MAE | Last HURLEY | Month Jan. | Day 26th | Year 19 57 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 22, 1914 | | 9. AGE (In years lost birthday) 42 yrs. | 10. IF UNDER 1 YEAR Months 0 Dots 0 Hours 0 Min. 0 | | 11. IF UNDER 24 HRS. Months 0 Dots 0 Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Winter Haven Florida | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | | |
| 13. FATHER'S NAME Charlie William Pressgray | | | 14. MOTHER'S MAIDEN NAME No Record | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Clifton James Hurley (Husband) Box# 194 Allen, Maryland (Near Salisbury) | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X | | | Bronchopneumonia | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of cervix c metastases to lungs & neck. | | | 7 months | | | | | | | | |
| DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) | | |
| 21. I certify that I attended the deceased from 1/31/57 , 19 57 , to 1/26/57 , 19 57 , that I last saw the deceased alive on 1/26/57 , 19 57 , and that death occurred at 11:15 P.M. from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) | | | | DATE SIGNED | |
| ACTUAL SIGNATURE <i>Willie H. Fisher Jr.</i> | | M.D. Medical Center | | | | | | Jan. 28 1957 | | | |
| PHYSICIAN'S NAME (Type) William H. Fisher Jr. | | M.D. Salisbury, Maryland | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 30, 1957 | | 22c. NAME OF CEMETERY OR CREMATORIUM Allen Cemetery | | 22d. LOCATION (City, town, or county) Allen Maryland | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY | | ADDRESS JAN 30 1957 | | 24d. REG'D BY REGISTRAR DATE | | 24c. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i> | | | | | |

WYOMING STATE DEPARTMENT OF HEALTH - DIVISION OF
CERTIFICATE OF DEATH

| | | | |
|--------------------------------------|--|--------------------------------------|--|
| NAME OF PERSON DIED | | NAME OF PERSON CERTIFYING | |
| MATERIAL | | MEDICAL | |
| AGE | | SEX | |
| DATE OF BIRTH | | DATE OF DEATH | |
| PLACE OF BIRTH | | PLACE OF DEATH | |
| NAME AND ADDRESS OF PHYSICIAN | | NAME AND ADDRESS OF HOSPITAL | |
| NAME AND ADDRESS OF FUNERAL DIRECTOR | | NAME AND ADDRESS OF CEMETERY | |
| NAME AND ADDRESS OF PERSON REPORTING | | NAME AND ADDRESS OF PERSON RECEIVING | |
| NAME AND ADDRESS OF PERSON SIGNING | | NAME AND ADDRESS OF PERSON SIGNING | |
| REASON FOR DEATH | | CAUSE OF DEATH | |
| SYMPTOMS | | DIAGNOSIS | |
| EXAMINATION | | TESTS | |
| TREATMENT | | MEDICATION | |
| LABORATORY TESTS | | TESTS | |
| EXAMINER'S SIGNATURE | | SIGNATURE | |

BUREAU V.
RECEIVED
JAN 30 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01220

1221

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | | | | | | | |
|--|--------------------------------------|---|--|--|---------------------------------------|---|-------------------|-----------------------------|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN lb 40 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 305 Park Ave. | | d. STREET ADDRESS 305 Park Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First WADE | Middle HAMPTON | Lost INSLEY, Sr. | 4. DATE OF DEATH 1 | Month 6 | Day 1957 | Year | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH March 29, 1877 | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Insurance Broker | | 10b. KIND OF BUSINESS OR INDUSTRY Life-Commercial | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME George Dallas Insley | | | 14. MOTHER'S MAIDEN NAME Susan Horsman | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Wade H. Insley, Jr. | | Address Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) coronary thrombosis | | | | | | | | | |
| DUE TO (c) arterio sclerosis | | | | | | | | | |
| DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Salisbury | | (County) Maryland | (State) Maryland |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) Salisbury, Maryland | | | | | | | | | |
| DATE SIGNED 1-7-57 | | | | | | | | | |
| ACTUAL SIGNATURE Philip A. Insley | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Philip A. Insley, 116 East Main St., Salisbury, Maryland | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 1/8/1957 | 22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery | | 22d. LOCATION (City, town, or county) Salisbury | | (State) Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. | | | ADDRESS Salisbury, Maryland | 24a. REC'D BY REGISTRAR DATE 1-7-57 | | 24b. REGISTRAR'S SIGNATURE Mary W. Holloman | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

29-10000

MURKIN

BALTIMORE CITY

| | | | |
|--|--|--|--|
| NAME AND ADDRESS OF DECEASED | | NAME AND ADDRESS OF PERSON REPORTING | |
| WILLIAM MURKIN 101 E. 20TH ST. BALTIMORE 2 | | JOHN W. HARRIS 101 E. 20TH ST. BALTIMORE 2 | |
| AGE SEX RACE MATERIAL TESTED | | DEATH CERTIFICATE NO. | |
| 65 M WHITE BLOOD | | 100-10000 | |
| CAUSE OF DEATH | | DATE OF DEATH | |
| CANCER OF LIVER | | JAN 8 1957 | |
| TIME OF DEATH | | TIME OF REPORT | |
| 10:00 A.M. | | 10:00 A.M. | |
| PLACE OF DEATH | | PLACE OF REPORT | |
| HOME | | HOSPITAL | |
| NAME OF DOCTOR | | NAME OF ATTENDING PHYSICIAN | |
| DR. JAMES C. COOPER | | DR. JAMES C. COOPER | |
| SIGNATURE OF REPORTER | | SIGNATURE OF ATTENDING PHYSICIAN | |
| JOHN W. HARRIS | | JOHN W. HARRIS | |
| RECEIVED | | RECEIVED | |
| FEB 1 1957 | | FEB 1 1957 | |

BUREAU V. 2

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01221

Reg. Dist. No. 332

| | | | | | |
|---|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Somerset</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> | | c. LENGTH OF STAY IN 1b <i>10 months</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Princess Anne</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>110 W Loudon St.</i> | | d. STREET ADDRESS <i>R.F.D. 1982</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First <i>Margaret</i> | Middle <i>L</i> | Last <i>Jackson</i> | 4. DATE OF DEATH <i>Jan 19 1957</i> | Month Day Year |
| 5. SEX <i>Females</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <i>Oct 27 1920</i> | 9. AGE (In years last birthday) <i>36 yrs.</i> | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>N.J.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | | | | |
| 13. FATHER'S NAME <i>Wellink & Miles</i> | | 14. MOTHER'S MAIDEN NAME <i>Miriam Jackson Princess Anne</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Miriam Jackson Princess Anne</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>592 X</i> | | CONGESTIVE HEART FAILURE | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| (b) | | DUE TO <i>HYPERTENSION</i> | | | |
| (c) | | DUE TO <i>CHRONIC NEPHRITIS & UREMIA</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>443 X</i> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <i>Salisbury</i> | (County) (State) |
| 21. I certify that I attended the deceased from <i>4/16/57</i> , 19 <i>55</i> , to <i>1/19/57</i> , 19 <i>57</i> . that I last saw the deceased alive on <i>4/19/57</i> , 19 <i>57</i> , and that death occurred at <i>12:00 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1/21/57</i> DATE SIGNED | | | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> | | M.D. | | | |
| PHYSICIAN'S NAME (Type) <i>O. J. Burton, M. D., 211 Maryland Ave., Salisbury, Md.</i> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | 22b. DATE THEREOF <i>1/22/57</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Salisbury Cemetery</i> | 22d. LOCATION (City, town, or county) <i>Mont Vernon</i> | (State) <i>MD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>James Dennis Princess Anne</i> | | ADDRESS <i>7</i> | 24a. REC'D BY REGISTRAR <i>DATE 1/23/57</i> | 24b. REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i> | |

87 390/AT100-104488 90-394444400 94AT2 CM 178M

BUREAU V. S.

JAN 24 1957

REGELEY ED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial trusty permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1223

CERTIFICATE OF DEATH

01222

332

Reg. Dist. No.

1. PLACE OF DEATHCOUNTY WicomicoCITY (If outside corporate limits, write RURAL
OR and give nearest town)TOWN SalisburyHOSPITAL OR
INSTITUTION OR
STREET ADDRESSPeninsula General Hospital

MARYLAND

LENGTH OF STAY
(In this place)**2. USUAL RESIDENCE (HOME) OF DECEASED**STATE MARYLANDCOUNTY Worcester

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWNSTREET
ADDRESSWhaleysville

(If rural give location)

**3. NAME OF
DECEASED**

(Type or Print)

AnnieMARYJones**4. DATE (Month)
OF
DEATH**JANUARY 20 1957**5. SEX**Female Colored**6. COLOR OR
RACE**Domestic**7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)**MARRIED**8. DATE OF BIRTH**Oct. 1, 1881**9. AGE last birthday**76 yrs.**10. IF UNDER 1 YEAR****IF UNDER 24 HRS.****Months Days Hours Min.****10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)**Domestic**10b. KIND OF BUSINESS
OR INDUSTRY**none**11. BIRTHPLACE (State or foreign country)**members see**12. CITIZEN OF WHAT
COUNTRY?**USA**13. FATHER'S NAME**John Roberts**14. MOTHER'S MAIDEN NAME**Henry Jones**15. WAS DECEASED EVER IN U. S. ARMED FORCES?****(Yes, no, or unk.)****(If Yes, give war or dates of service)**None**16. SOCIAL SECURITY NO.**517-14-8482**17. INFORMANT & ADDRESS**Handy Jones**18. MEDICAL CERTIFICATION****I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**570.2 IMMEDIATE CAUSE(A) DUE TODISEASES OR CONDITIONS, IF ANY,GIVING RISE TO THE ABOVE CAUSESTATING UNDERLYING CAUSE LAST.(B) DUE TO414(C) DUE TOHypertensive cardiovascular disease.Gardias failure.Prolonged vomiting with electrolyte imbalanceDuodenal obstruction from hyp. Mesenteric arteryHypertensive cardio vascular disease.INTERVAL BETWEEN
ONSET AND DEATH**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**

DEPARTMENT OF HUMAN RELATIONS

CERTIFICATE OF DATA

BUREAU V. 2

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01223

1224

CERTIFICATE OF DEATH

Reg. Dist. No. 337

| | | | |
|--|---------------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Salisbury | | c. LENGTH OF STAY IN 1b 12 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | e. STREET ADDRESS 312 E. William St | |
| 3. NAME OF DECEASED (Type or print) First MANORA | | Middle ALICE | Last JUSTIS |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH June 3, 1888 |
| 9. AGE (In years lost birthday) 68 yrs. | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator & Owner of Justis Apartment House | | 10b. KIND OF BUSINESS OR INDUSTRY R.D.# Salisbury, Md. | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William James Toadvine | | 14. MOTHER'S MAIDEN NAME Clara Emily Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Irma M. Bradley (Sister) R.D.# 1 Salisbury, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebrovascular Accident INTERVAL BETWEEN ONSET AND DEATH 4 weeks DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic Cardiovascular Dis. 8-10 yrs DUE TO (c) Paroxysmal auricular Tachycardia 11 Renal abscess, left kidney | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Renal abscess, left kidney | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11, 1927, to 1/30, 1957, that I last saw the deceased alive on 1/30, 1957, and that death occurred at 753 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. Rufus S. Gardner Jr. M.D. S. Division St. (Office) DATE SIGNED Feb 1st 1957 Feb 1st 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 2, 1957 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery | | 22d. LOCATION (City, town, or county) Salisbury, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | 24a. REC'D BY REGISTRAR FEB 4 1957 DATE | |
| | | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - MARYLAND

CERTIFICATE OF DEATH

BUREAU V.

FEB 4 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01224

CERTIFICATE OF DEATH

1260

Reg. Dist. No. 337

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN | Wicomico Tyaskin | MARYLAND LENGTH OF STAY (in this place) | STATE Maryland COUNTY Wicomico CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Tyaskin STREET ADDRESS |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | Lifetime | |
| 3. NAME OF DECEASED (Type or Print) | | (First) Emma | (Middle) Larmore |
| (Last) | 4. DATE OF DEATH Jan. 25, 1957 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced | 8. DATE OF BIRTH 2/27/1877 |
| 9. AGE last birthday 79 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | 13. FATHER'S NAME George E. Larmore | | |
| 14. MOTHER'S MAIDEN NAME Mary E. Hemmons | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 420.1 IMMEDIATE CAUSE (A) Acute Coronary Occlusion | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arterio sclerosis. | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) 10 Years. | | | |
| STATING UNDERLYING CAUSE LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 2 Hours. | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 5/19, 1950, to 1/25, 1957, that I last saw the deceased alive on 1/25, 1957, and that death occurred at 3 A.M. from the causes and on the date stated above. | | | |
| SIGNATURE Richard H. Saunders | | ADDRESS (Street, city, town, state) Nanticoke, Md. | |
| DATE SIGNED 1/27/57 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 1/27/57 | |
| NAME OF CEMETERY OR CREMATORIAL Tyaskin Cemetery | | LOCATION (City, town, or county) Tyaskin, Maryland | |
| 24. REG'D BY REGISTRAR FEB 4 1957 | | REGISTRAR'S SIGNATURE | |
| 25. FUNERAL DIRECTOR'S SIGNATURE Mary H. Holloway | | ADDRESS C. J. Jessick, Bivalve, Maryland | |
| DATE | | | |

WISCONSIN STATE DEPARTMENT OF NATURAL RESOURCES

CERTIFICATE OF DEATH

REG. NO. 100

APPROVED FOR RECORD BY DIRECTOR

REG. NO. 100

APPROVED FOR RECORD

STATE
OF WISCONSIN
DEPARTMENT OF
NATURAL RESOURCES

REG. NO. 100

APPROVED FOR RECORD

BUREAU V.

REG. NO. 100

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01225

1225 CERTIFICATE OF DEATH

Reg. Dist. No. 332

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10-W

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | MARYLAND LENGTH OF STAY (in this place) 4 HRS. | STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN | COUNTY MARYLAND COUNTY WICOMICO DELMAR (If rural give location) |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Peninsula General Hospital R.F.D. | | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| (First) HOWARD JAMES MADDox | | (Month) (Day) (Year) JANUARY 7 1957 | |
| 5. SEX MALE | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH 4-6-1889 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). TOREMAN | 10b. KIND OF BUSINESS OR INDUSTRY RAILROAD | 11. BIRTHPLACE (State or foreign country) WICOMICO COUNTY USA | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME GEORGE M. MADDox | 14. MOTHER'S MAIDEN NAME OLEVIA CAMPBELL | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO | 16. SOCIAL SECURITY NO. 716-01-9421 | 17. INFORMANT & ADDRESS BERTIE A. MADDox-DELMAR | 18. MEDICAL CERTIFICATION Myocardial Infarct Anterior subacute coronary thrombosis |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Myocardial Infarct ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause STATING UNDERLYING CAUSE LAST. DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 4 hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 1-7, 1957, to 1-7, 1957, that I last saw the deceased alive on 1-7, 1957, and that death occurred at 11:25 P.M., from the causes and on the date stated above. | | | |
| SIGNATURE William Q. Ellis Jr. | M.D. | ADDRESS (Street, city, town, state) Salisbury, Md | DATE SIGNED 1-7-57 |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | DATE THEREOF 1-10-1957 | NAME OF CEMETERY OR CREMATORIAL Max Olive | LOCATION (City, town, or county) Delmar, Del |
| 24. REC'D BY REGISTRAR IAN 11 1957 | REGISTRAR'S SIGNATURE Mary H. Holloway | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. S. Grand Co - Delmar, Del | |

DEPARTMENT OF HEALTH-EDUCATION-WEAVER

1953 CERTIFICATE OF DEATH

SEARCHED

SEARCHED, SERIALIZED, INDEXED AND FILED

SEARCHED

SEARCHED
INDEXED
FILED

BUREAU U. S.

JAN 11 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**1226 CERTIFICATE OF DEATH**

Reg. Dist. No.

01226
338

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS | MARYLAND LENGTH OF STAY (in this place) 14 days | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS 23x02 | MARYLAND COUNTY Worcester Girdletree (If rural give location) |
| 3. NAME OF DECEASED (Type or Print) Amanda W. Mariner | | 4. DATE OF DEATH January 16 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH May 25, 1860 |
| 9. AGE last birthday 96 | 10. KIND OF BUSINESS OR INDUSTRY Housewife | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Lenox Ailsworth | | 14. MOTHER'S MAIDEN NAME Mary Ann Lang | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT & ADDRESS Mrs Rena Jackson, Girdletree, Md. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH unrecorded | |
| ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) | | DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from.....12/31/.....1956....., to.....1-12-1957....., that I last saw the deceased alive on.....11/15....., 1957, and that death occurred at.....153.....A.M., from the causes and on the date stated above. | | | |
| SIGNATURE Willie R. Ellis Jr. | | ADDRESS (Street, city, town, state) Salisbury, Md. 21801 | |
| DATE SIGNED 1-17-57 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 1-17-57 | NAME OF CEMETERY OR CREMATORIUM Nelson Cemetery | LOCATION (City, town, or county) Rural Pocomoke City, Md. |
| 24. REC'D BY REGISTRAR DATE AN 21 1957 | REGISTRAR'S SIGNATURE Mary H. Holloway | 25. FUNERAL DIRECTOR'S SIGNATURE Henry Watson (Pocomoke) | ADDRESS Md. |

DEPARTMENT OF HEALTH-EQUITY

CERTIFICATE OF DEATH

Form No. 5

RECEIVED IN OFFICE OF THE SECRETARY

RECEIVED IN OFFICE OF THE SECRETARY

STATE
OF
WYOMING

DEATH CERTIFICATE

STATE
OF
WYOMING

BUREAU A.

JAN 21 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01227

331

CERTIFICATE OF DEATH

1227

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Wicomico</u> MARYLAND | | STATE <u>MARYLAND</u> , COUNTY <u>WORCESTER</u> | |
| CITY (If outside corporate limits, write RURAL OR end give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| TOWN <u>SALISBURY</u> | | TOWN <u>Pocomoke, 23x02</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| <u>PENINSULA GENERAL HOSPITAL</u> | | <u>Route #2.</u> | |
| 3. NAME OF DECEASED (First) <u>Bertie</u> (Middle) <u>J.</u> (Last) <u>MARRINER</u> | | 4. DATE (Month) <u>JANUARY</u> (Day) <u>26</u> (Year) <u>1957</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>SEPT. 25, 1895</u> |
| 9. AGE last birthday <u>61</u> yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>WILLIAM GIBBONS</u> | 14. MOTHER'S MAIDEN NAME <u>MARY ANN DRYDEN</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT & ADDRESS <u>MR. ALEX S. MARINER, POCOMOKE, MD</u> | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, (B) _____ | | | |
| GIVING RISE TO THE ABOVE CAUSE | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19e. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____ | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from..... | | | |
| alive on <u>1/23</u> , 19 <u>57</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Frederick R. Grammer</u> ADDRESS (Street, city, town, state) <u>M.D. Salisbury, Md</u> DATE SIGNED <u>1/27/57</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried 1957</u> | | DATE THEREOF <u>1-27-57</u> NAME OF CEMETERY OR CREMATORIUM <u>BAPTIST CEMETERY</u> | |
| LOCATION (City, town, or county) <u>Pocomoke, Md</u> (State) <u></u> | | 24. REC'D BY REGISTRAR <u>Mary H. Hallaway</u> REGISTRAR'S SIGNATURE | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson (Pocomoke, Md)</u> ADDRESS | | DATE <u>JAN 28 1957</u> | |

REAU V. S.

JAN 28 1957

PEGEIY E

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01228

1228

CERTIFICATE OF DEATH

Reg. Dist. No.

332

| | | | | | | | | |
|---|---|--|--|--|---|--|------------------------|-----------------------|
| 1. PLACE OF DEATH o. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland | | b. COUNTY Wicomico | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 4 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Mardela Springs (Rural) | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | | | d. STREET ADDRESS R.D. # Division St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First VIOLET | Middle MARY | Last NICHOLS | 4. DATE OF DEATH | Month Jan. | Day 23, | Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Nov. 23, 1885 | 9. AGE (In years last birthday) 71 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) New York City | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME William Harding | | | | 14. MOTHER'S MAIDEN NAME Margaret Atchison | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT Mrs. Marcelle Johnson (Niece) New York City N.Y. Deer's Head Hospital Records, Salisbury, Md. | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 422.1 | | | | | | | | |
| (b) DUE TO Old cardiovascular accident | | | | | | | | |
| (c) | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH ? | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old cardiovascular accident | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- | | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month Sept. | Day 24 | Year 1956 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) --- | (County) --- | (State) --- |
| 21. I certify that I attended the deceased from Sept. 24, 1956 , to Jan. 23, 1957 , that I last saw the deceased alive on Jan. 23, 1957 , and that death occurred at 11:42 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) --- | | | | | | | | |
| DATE SIGNED 1/23/57 | | | | | | | | |
| ACTUAL SIGNATURE L. V. Maldve, M. D. | | | | | | | | |
| PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan. 26, 1957 | 22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery | | | 22d. LOCATION (City, town, or county) Salisbury, Maryland | | | |
| (State) MD | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | | | | | | | |
| 24a. REC'D BY REGISTRAR DATE JAN 25 10 | | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—DEPARTMENT OF

CERTIFICATE OF DEATH

BUREAU V. S

JAN 25 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

Vs AISC 1-5 10M
1229

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01229

1229 CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATHCOUNTY WicomicoCITY (If outside corporate limits, write RURAL
OR end give nearest town)TOWN SALISBURYHOSPITAL OR
INSTITUTION OR
STREET ADDRESSPENINSULA GENERAL HOSPITAL

MARYLAND

LENGTH OF STAY
(In this place)3 Weeks**2. USUAL RESIDENCE (HOME) OF DECEASED**STATE MARYLANDCOUNTY WORCESTER

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWNSTREET
ADDRESSSNOW HILL

(If rural give location)

23 X 02209 FEDERAL ST.**3. NAME OF
DECEASED**
(Type or Print)SEX MALECOLOR OR
RACE WHITE10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY Trained Merchant

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?Grocery StoreSnow Hill, MdGeorge W ParsonsElizabeth E. Holston13. FATHER'S NAME
(Yes, no, unk.)

(If Yes, give war or dates of service)

George W ParsonsMiss Julia W Parsons, Snow Hill, Md15. WAS DECEASED EVER IN U.S. ARMED FORCES?16. SOCIAL SECURITY NO.17. INFORMANT & ADDRESS18. MEDICAL CERTIFICATION4222 IMMEDIATE CAUSEANTECEDENT CAUSE(S) DUE TODISEASES OR CONDITIONS, IF ANY, (B)GIVING RISE TO THE ABOVE CAUSESTATING UNDERLYING CAUSE LAST. DUE TO(C)19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTINGTO THE DEATH BUT NOT RELATED TO THEDISEASE OR CONDITION CAUSING DEATH.20. AUTOPSYYES NO INTERVAL BETWEENONSET AND DEATHunknown21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,OF INJURY street, office bldg., etc.)21c. WHERE DID INJURY OCCUR? (City or town)(County)(State)21d. TIME OF INJURY (Month) (Day) (Year) (Hour)M. at work Not while at work 21e. INJURY OCCURREDM.D.21f. HOW DID INJURY OCCUR?1-26-5722. I hereby certify that I attended the deceased from 1-4-57, 1957, to 1-26, 1957, that I last saw the deceasedalive on 1-26, 1957, and that death occurred at 10:15 A.M. from the causes and on the date stated above.SIGNATUREWilliam R. EllingtonM.D.ADDRESS (Street, city, town, state)Salesbury, MdDATE SIGNED1-26-5723. BURIAL, CREMATION,REMOVAL (SPECIFY)24. REC'D BY REGISTRARDATEJAN 29 1957REGISTRAR'S SIGNATUREMary H. HollowayADDRESSSnow Hill, Md25. FUNERAL DIRECTOR'S SIGNATUREElbert Morris, Snow Hill, MdADDRESS

BUREAU V. S.

JAN 29 1957

RECEIVED JAN 20

01230
332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1261

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

| | | | | | | | |
|---|------------------------------------|--|--|--|--------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rural Salisbury (Walston) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# Salisbury (Walston) | | | | d. STREET ADDRESS R.D.# 3 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ANTHONY Middle GOLDSBOROUGH Last PERDUE | | | | 4. DATE OF DEATH JANUARY 18th 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH March 22, 1879 | 9. AGE (In years last birthday) 77 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John James Perdue | | | | 14. MOTHER'S MAIDEN NAME Hester Ennis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Irma M. Kelley (Daughter) Address Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.0</i> DUE TO <i>Arteries, Delusive heart disease, year</i> Conditions, if any, which gave rise to immediate cause (b) <i>Arteries, Delusive heart disease, year</i> (c) <i>Actual cause lost.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i> DUE TO <i>None</i> (c) <i>None</i> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Royer</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED Jan. 19 1957 | | | |
| EXAMINER'S NAME (Type) Dr. Earl L. Royer | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan. 20, 1957 | 22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery | 22d. LOCATION (City, town, or county) R.D.# Salisbury (Walston) Md. | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | ADDRESS AN | 24a. REC'D BY REGISTRAR 21 1957 | 24b. REGISTRAR'S SIGNATURE <i>Mary Holloway</i> | | | |

BUREAU A.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01231
337

1262

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | |
|---|----------------------------------|---|---|--|---------------------------------------|--|-------------------|------------------------------------|----------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron | | c. LENGTH OF STAY IN 1b x2 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main St | | d. STREET ADDRESS Main St | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | First SENERA | Middle BELITHA | Last PHILLIPS | 4. DATE OF DEATH JAN 20th 1957 | Month Day Year | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH March 15, 1908 | 9. AGE (In years last birthday) 48 | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator (Employee) | | 10b. KIND OF BUSINESS OR INDUSTRY Pants Factory | | 11. BIRTHPLACE (State or foreign country) Laurel, Delaware | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Fredrick B. Joseph | | 14. MOTHER'S MAIDEN NAME Hattie Ann Cannon | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Guss A. Phillips (Husband) | | Address Main St Hebron, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema | | DUE TO 153X | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | (b) Acute Nephritis | | | | | | | |
| (c) Tumor of Intestinal Tract | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Laurel | | (County) Delaware | (State) MD |
| 21. I certify that I attended the deceased from Jan 3rd 1957 to Jan 20 1957 , that I last saw the deceased alive on Jan 20 1957 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. | | | | | | ADDRESS (Street, city or town, state) Laurel, Delaware | | DATE SIGNED Jan. 21 1957 | |
| ACTUAL SIGNATURE Vernon A. Spitznagle | | M.D. (Office) | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Vernon A. Spitznagle | | M.D. | | Mardela, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 23. 1957 | | 22c. NAME OF CEMETERY OR CREMATORIUM Odd Fellow Cemetery | | 22d. LOCATION (City, town, or county) Laurel, Delaware | | (State) MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | ADDRESS | | 24a. REC'D BY REGISTRAR JAN 22 1957 | | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 22 1957

REGELVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1230

CERTIFICATE OF DEATH

01232

Reg. Dist. No.

331

| | | | | | | | | |
|---|---------------------------|---|--|---|--|--|---|------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | | | d. STREET ADDRESS Pemberton Drive | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First GRAHAM | Middle JOHN | Last PRETTYMAN | 4. DATE OF DEATH | Month JAN. | Doy 5 th | Year 19 52 7 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 13, 1910 | | 9. AGE (In years lost birthday) 46 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Employee) | | | 10b. KIND OF BUSINESS OR INDUSTRY Grocery Store | | 11. BIRTHPLACE (State or foreign country) Salisbury, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ray Prettyman | | | 14. MOTHER'S MAIDEN NAME Maude Figgs | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Inez J. Prettyman (Wife) Address Pemberton Drive Salisbury, Maryland | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO <i>hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>esophageal varices</i> DUE TO (c) <i>cirrhosis of the liver</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days. 6 mos. 1 yrs. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Maryland Ave. (Office) | | (County) (State) |
| 21. I certify that I attended the deceased from 11/25, 1956, to 1/5, 1957, that I last saw the deceased alive on 11/7, 1957, and that death occurred at 6:00 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Er. Earl Beardsley</i> M.D. ADDRESS (Street, city or town, state) <i>Maryland Ave. (Office)</i> DATE SIGNED <i>Jan. 5, 1957</i> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 8, 1957 | | 22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery | | 22d. LOCATION (City, town, or county) Salisbury, Maryland | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD. | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE N 8 1957 | | 24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MATERIALS STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DATA

| | | | | |
|--------------|----------|---------|------------|-------|
| RECEIVED | SEARCHED | INDEXED | SERIALIZED | FILED |
| JAN 8 1957 | | | | |
| BUREAU A. A. | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1231

CERTIFICATE OF DEATH

11233
332

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | d. STREET ADDRESS 648 S. Salisbury Blvd. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) REIGART | First HENRY | Middle | Last RIDER | 4. DATE OF DEATH 1 22 1957 | Month 1 | Day 22 | Year 1957 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH June 22, 1893 | 9. AGE (In years lost birthday) yrs. 63 | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. IF UNDER 24 HRS. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Distributor | | 10b. KIND OF BUSINESS OR INDUSTRY Distributor | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Rider | | 14. MOTHER'S MAIDEN NAME Catherine Fessler | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. R.H. Rider, Same | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Hyfertension. DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | | Month 19 | Day | Year | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 10/15/53 , 19 53 , to 1/23 , 19 57 , that I last saw the deceased alive on 1/23 , 19 57 , and that death occurred at 1 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 1/24/57 | | | | | | | |
| ACTUAL SIGNATURE A.C. Mitchell | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell, 211 Maryland Ave., Salisbury, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1/25/57 | 22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park | 22d. LOCATION (City, town, or county) Salisbury, Maryland (State) | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland | | 24a. REC'D BY REGISTRAR Norman T. Baker | 24b. REGISTRAR'S SIGNATURE Mary W. Holloway | | | | |
| | | DATE 1-24-57 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

IAN 28 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01234

1232

CERTIFICATE OF DEATH

Reg. Dist. No.

332

| | | | | | | | | | | | |
|---|---------------------------------|--|---------------------------------------|--|---|--|---------------------|---|-------------------|--|-------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 40 years | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - 109 Morris Lane | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | d. STREET ADDRESS 109 Morris Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Frances | First | Middle Emily | Last Roberts | 4. DATE OF DEATH 1 - 21 - 1957 | Month | Day | Year | | | | |
| 5. SEX Female | 6. COLOR OR RACE A.A. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH 12-15-1876 | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR 1 | IF UNDER 24 HRS. 6 | Months 1 | Days 6 | Hours 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Cook | | 11. BIRTHPLACE (State or foreign country) Oriole, Somerset Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Benjamin Roberts | | | | 14. MOTHER'S MAIDEN NAME Mary Davis | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Miss Helen Roberts, Baltimore, Maryland | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO <i>Cardiovascular renal disease</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. p. p. m. | | Month 19 | Day | Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. | | | | | | | | | | ADDRESS (Street, city or town, state) | DATE SIGNED |
| ACTUAL SIGNATURE <i>Kluger Inslay</i> | | PHYSICIAN'S NAME (Type) <i>Philip A. Inslay</i> | | | | | | | | <i>Salisbury, Md. 1-23-57</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-24-57 | | 22c. NAME OF CEMETERY OR CREMATORIUM Oriole Cemetery | | 22d. LOCATION (City, town, or county) Oriole, Somerset Co., Md. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Stewart Funeral Home, Salisbury, Md.</i> | | | | ADDRESS | | 24a. REC'D BY REGISTRAR <i>JAN 24 1957</i> | | 24b. REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JAN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1233 CERTIFICATE OF DEATH

Reg. Dist. No. 11235
337

Dr. C.J. Burton M.D.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH

COUNTY Wicomico
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN Salisbury

MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN SalisburyCOUNTY WicomicoSTREET ADDRESS 1 647 Fitzwater Street
(If rural give location)3. NAME OF
DECEASED
(Type or Print)OraLILLIANRyall

4. DATE (Month) (Day) (Year)

OF DEATH JANUARY 21 1957

5. SEX

6. COLOR OR
RACE Female White10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) House Work7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Married10b. KIND OF BUSINESS
OR INDUSTRY None8. DATE OF BIRTH February 20, 18919. AGE last birthday 65
yrs. 11 months 1 days 0 hours 0 min.11. BIRTHPLACE (State or foreign country) R.D. # White Haven, Maryland12. CITIZEN OF WHAT
COUNTRY? U.S.A.13. FATHER'S NAME Charles H. Taylor14. MOTHER'S MAIDEN NAME Lillie Reese15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS Mr. Robert B. Ryall (Husband) 647 Fitzwater
St. Salisbury, MarylandINTERVAL BETWEEN
ONSET AND DEATH

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A)ANTECEDENT CAUSE(S) (B) DUE TODISEASES OR CONDITIONS, IF ANY, (C) DUE TOGIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

DISEASE OR CONDITION CAUSING DEATH.

18. MEDICAL CERTIFICATION

MYOCARDIAL INFARCTIONCORONARY ATHEROSCLEROSISHYPERTENSIVE CARDIO VASCULAR
ATHEROSCLEROSISII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County) Wicomico (State) Maryland

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

19. 54, to 1/21/57, 19 57, that I last saw the deceasedalive on 1/21/57, 19 57, and that death occurred at 12:50 P.M., from the causes and on the date stated above.SIGNATURE C.J. Burton

ADDRESS (Street, city, town, state)

DATE SIGNED January 21, 195723. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF Jan. 24, 1957

NAME OF CEMETERY OR CREMATORIAL

Fruitland Cemetery

LOCATION (City, town, or county)

(State) Maryland

24. REC'D BY REGISTRAR

DATE Jan. 23 1957REGISTRAR'S SIGNATURE Mary H. Holloway

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS HOLLOWAY & COMPANY - SALISBURY, MARYLAND

DEPARTMENT OF INTERNAL AFFAIRS

CERTIFICATE OF DEATH

W. J. H. G.

W. J. H. G.

W. J. H. G.

W. J. H. G. 1952

W. J. H. G.

BUREAU V.
JAN 23 1957
RECEIVED

1/25/57

1/25/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01236

Reg. Dist. No.

337

1234

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Nanticoke

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Peninsula General Hospital

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Newborn

Middle
Baby

Last
John Sheffield

4. DATE
OF
DEATH

Month
1

Day
6

Year
1957

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

1-6-56

9. AGE (In years
last birthday)
yrs.

IF UNDER 1 YEAR

Months
Days

IF UNDER 24 HRS.

Hours
6

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Sherman Gordon

14. MOTHER'S MAIDEN NAME

Emma Lee Sheffield

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

James Mac Daniel, Nanticoke, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Congenital atelectasis

INTERVAL BETWEEN
ONSET AND DEATH

Sudden.

762.5

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Prematurity

6 hours

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Earl L. Royer, M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

1-7-57

22a. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)
(State)

23. FUNERAL DIRECTOR'S SIGNATURE

24a. REC'D BY REGISTRAR

ADDRESS

24b. REGISTRAR'S SIGNATURE

DATE

JAN 18 1957

1000162XV

Mary H. Hollaway

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

WITNESS STATEMENT OF DEATH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y.

JAN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01237

Reg. Dist. No. 332

1235

CERTIFICATE OF DEATH

| | | | | | | | | |
|--|-------------------------------------|---|---|--|---|--|---|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 10 Min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | d. STREET ADDRESS 205 E. Isabella St., | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Penisnspulan General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | First ELIZABETH | Middle TILGHMAN | Last SMACK | 4. DATE OF DEATH | Month 1 | Day 19 | Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | B. DATE OF BIRTH Mar. 5, 1886 | 9. AGE (In years lost birthday) 70 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Thomas H. Tilghman | | | 14. MOTHER'S MAIDEN NAME Mary Collins | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Irma Tilghman, Same | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause pertine for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary</i> <i>Hypertension</i> INTERVAL BETWEEN ONSET AND DEATH <i>hrs.</i> | | | | | | | | |
| 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congestive heart failure</i> <i>myocardial degeneration</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>1957</i> | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Day | Year | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) <i>Salisbury</i> | (County) <i>Wicomico</i> | (State) <i>Maryland</i> |
| 21. I certify that I attended the deceased from <i>1/25/57</i> , to <i>1/19/57</i> , that I last saw the deceased alive on <i>1/19/57</i> , and that death occurred at <i>205 E. Isabella St., Salisbury, Maryland</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Salisbury, Maryland</i> DATE SIGNED <i>1/21/57</i> | | | | | | | | |
| ACTUAL SIGNATURE <i>Earl Beardsley</i> M.D. | | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Earl Beardsley, 207 Maryland Ave., Salisbury, Maryland | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1/21/57 | 22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery | | | 22d. LOCATION (City, town, or county) Salisbury, Maryland (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co., Salisbury, Maryland | | | ADDRESS <i>Norman T. Baker</i> | | 24a. REC'D BY REGISTRAR DATE 1-20-57 | | 24b. REGISTRAR'S SIGNATURE Mary W. Holloway | |

WISCONSIN STATE GOVERNMENT OF HEALTH-DEPARTMENT

CERTIFICATE OF DEATH

BUREAU V. A.

JAN 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01238

Reg. Dist. No.

337

CERTIFICATE OF DEATH

1235

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | c. LENGTH OF STAY IN lb 8 months | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | d. STREET ADDRESS 408 Goldsborough |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Anna | Middle M. | Last Smith |
| 4. DATE OF DEATH Jan. 2 1957 | Month | Day | Year |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/3/1871 |
| 9. AGE (In years last birthday) 85 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) Oxford, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Meade Bayne | | 14. MOTHER'S MAIDEN NAME Anna Singleton Bayne | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 2 days Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause last. (b) DUE TO Arteriosclerosis generalized ? (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20c. TIME OF INJURY Hour o. g. p. m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oxford | 20f. (City or town) (County) (State) Oxford (Baltimore) MD |
| 21. I certify that I attended the deceased from April 25, 1956, to Jan. 2, 1957, that I last saw the deceased alive on Jan. 2 1957, and that death occurred at 10:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE L. V. Maldve, M. D. Deer's Head State Hospital DATE SIGNED 1/2/57 | | | |
| PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | Salisbury, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 5 1957 | 22b. DATE THEREOF Jan. 5 1957 | 22c. NAME OF CEMETERY OR CREMATORIAL Oxford Cemetery | 22d. LOCATION (City, town, or county) Oxford (State) MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newell & Son | | ADDRESS Easton MD | 24a. REC'D BY REGISTRAR DATE Jan 8 1957 |
| | | | 24b. REGISTRAR'S SIGNATURE Mary J. Holloway |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V.

JAN 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01239
332

Reg. Dist. No.

1237

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury, Maryland

c. LENGTH OF STAY IN 1b

4 mo. 29 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Queen Anne's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chestertown,

1702

3. NAME OF DECEASED (Type or print)

First Dorothy

Middle Mae

Last Smith

4. DATE OF DEATH

Jan.

21

Day Year
19 57

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

June 13, 1909

9. AGE (In years last birthday) yrs.

41

10. IF UNDER 1 YEAR

Months Doy

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

unk

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Alpheus Andrews

14. MOTHER'S MAIDEN NAME

Mary Mae Magnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

unk

16. SOCIAL SECURITY NO.

unk

17. INFORMANT

Hospital Records

Address

Salisbury, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Generalized carcinomatosis

INTERVAL BETWEEN
ONSET AND DEATH
?

170X

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

(b)
Ca. of breast

2 years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a. m.

19

p. m.

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Aug. 83, 1956, to Jan 21, 1957, that I last saw the deceased alive on Jan. 21, 1957, and that death occurred at 7:10 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

L. V. Maldve, M.D.

M.D.

Jan. 22, 1957

Salisbury, Md.

22a. BURIAL OR CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Jan. 24

22c. NAME OF CEMETERY OR CREMATORI

Crumpton

22d. LOCATION (City, town, or county)

Crumpton, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Edgar L. Maldve

ADDRESS

Church Hill, Md.

24a. REC'D BY REGISTRAR

DATE

Jan. 24, 1957, Mary F. Holloway

WISCONSIN STATE DEPARTMENT OF HEALTH - MARCH 1957

CERTIFICATE OF DEATH

| | | | |
|---|------|-----|---------------------|
| DECEASED'S NAME | SEX | AGE | CAUSE OF DEATH |
| ROBERT L. HORN | MALE | 40 | ACUTE HEART DISEASE |
| DECEASED'S ADDRESS | | | |
| 101 N. 10TH ST., MILWAUKEE, WIS. | | | |
| NAME AND ADDRESS OF DOCTOR | | | |
| DR. JAMES R. COOPER, 101 N. 10TH ST., MILWAUKEE, WIS. | | | |
| TIME AND PLACE OF DEATH | | | |
| 10:30 A.M., 2/24/57, AT HOME | | | |
| METHOD OF DEATH | | | |
| NATURAL | | | |
| TIME OF DEATH | | | |
| 10:30 A.M. | | | |
| NAME OF PERSON REPORTING | | | |
| JOHN HORN, SON | | | |
| RELATIONSHIP TO DECEASED | | | |
| SON | | | |
| NAME OF PERSON SIGNING | | | |
| JOHN HORN | | | |
| SIGNATURE | | | |
| MILWAUKEE, WISCONSIN | | | |
| JAN 24 1957 | | | |
| RECEIVED | | | |

BUREAU V. S.

JAN 24 1957

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 15-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01240

331

CERTIFICATE OF DEATH

1238

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>SALISBURY</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL 46X-3 R 7 D H 1</u> | | MARYLAND LENGTH OF STAY (In this place) <u>7 days</u> STATE <u>DELAWARE</u> COUNTY <u>SUSSEY</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DELMAR</u> STREET ADDRESS (If rural give location) <u>1401</u> | |
| 3. NAME OF DECEASED (First) <u>Ethel</u> (Middle) <u>S.</u> (Last) <u>Smith</u> (Type or Print) | | 4. DATE (Month) <u>JANUARY</u> (Day) <u>13</u> (Year) <u>1957</u> OF DEATH | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>7-10-1883</u> |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | |
| 13. FATHER'S NAME <u>JOSIAH KENNEY</u> | | 14. MOTHER'S MAIDEN NAME <u>MAGGIE SIRMAN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT & ADDRESS <u>CHAS V. SMITH - DELMAR-DE</u> | | 18. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u> ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE _____ STATING UNDERLYING CAUSE LAST. DUE TO _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____ | |
| 21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____ | | 21d. TIME OF INJURY (Month) <u>January</u> (Day) <u>13</u> (Year) <u>1957</u> 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., M., from the causes and on the date stated above. SIGNATURE <u>Willie B. Ellis, Jr.</u> M.D. ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>1-13-57</u> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> DATE THEREOF <u>1-16-1957</u> NAME OF CEMETERY OR CREMATORIAL <u>MT. OLIVE</u> LOCATION (City, town, or county) <u>DELMAR-DEL-</u> (State) <u>MD</u> | | | |
| 24. REC'D BY REGISTRAR DATE <u>JAN 17 1957</u> | | REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. S. Mandel Co - Delmar, Md.</u> | |

U.S. GOVERNMENT PRINTING OFFICE: 1957 2-1000

DEPARTMENT OF DEFENSE

OPTIONAL FORM NO. 10 (MAY 1957) GSA GEN. REG. NO. 27, 1957

BUREAU V. S.

JAN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1239

CERTIFICATE OF DEATH

01241
337

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Somerset | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 19 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 19-39-2 Crisfield | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | | | | | | |
|---|----------------------|--|------------------|------------------------------------|---------------------------|--------------------------|---------------------|
| 3. NAME OF DECEASED (Type or print) | First MYRA | Middle | Last | 4. DATE OF DEATH | Month 1 | Day 25 | Year 1957 |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |

| | | | | | | | |
|--|-------|-----------------------------------|-----------------------------------|---|---------|------------------------------|--|
| Female | White | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | Oct. 22, 1866 | 90 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| House Wife | | Own Home | | Maryland | | U.S.A. | |

| | | |
|---|---|---|
| 13. FATHER'S NAME Leonard Sterling | 14. MOTHER'S MAIDEN NAME Elona Cullen | Address |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Records John B. Parsons Home, Same |

| | |
|---|-------------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) <i>Generalized Arterio Sclerosis</i> | |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
|--|--|---|

| | | | |
|---|--|---|---|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |

| | | | | | |
|--|--|--|--|---------------------------------------|-------------------------------|
| 21. I certify that I attended the deceased from 1955 , 19, to 1/22 , 19 56 , that I last saw the deceased alive on 1/21/56 , 19, and that death occurred at 2:20 AM , from the causes and on the date stated above. | | | | ADDRESS (Street, city or town, state) | DATE SIGNED 1/21/57 |
|--|--|--|--|---------------------------------------|-------------------------------|

| | | | |
|--|------|---------------------|---|
| ACTUAL SIGNATURE <i>Fred R. Gramse</i> | M.D. | Salisbury, Maryland | PHYSICIAN'S NAME (Type) Dr. Fred Gramse, 402 South Division St., Salisbury, Maryland |
|--|------|---------------------|---|

| | | | | |
|---|-------------------------------------|---|---|---------|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1/27/57 | 22c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery | 22d. LOCATION (City, town, or county) Crisfield, Maryland | (State) |
|---|-------------------------------------|---|---|---------|

| | | | |
|---|-----------------------------------|---|---|
| 23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland | ADDRESS Norman T. Baker | 24a. REC'D BY REGISTRAR DATE JAN 28 1957 | 24b. REGISTRAR'S SIGNATURE Mary J. Holloway |
|---|-----------------------------------|---|---|

WYOMING STATE DEPARTMENT OF REVENUE - BILLIMORE 16

CERTIFICATE OF DEATH

| | | | |
|--------------------------------------|-----|-----|----------------|
| DECEASED'S NAME | AGE | SEX | CAUSE OF DEATH |
| EDWARD L. HARRIS | 60 | M | HEART DISEASE |
| DECEASED'S ADDRESS | | | |
| 101 E. 2ND ST. | | | |
| LARAMIE, WYOMING | | | |
| NAME AND ADDRESS OF DOCTOR | | | |
| DR. JAMES R. COOPER | | | |
| LARAMIE, WYOMING | | | |
| TIME AND PLACE OF DEATH | | | |
| 10:00 A.M. - 101 E. 2ND ST. | | | |
| LARAMIE, WYOMING | | | |
| NAME AND ADDRESS OF FUNERAL DIRECTOR | | | |
| J. C. COOPER | | | |
| LARAMIE, WYOMING | | | |
| DATE OF DEATH | | | |
| JAN 28, 1957 | | | |
| RECEIVED | | | |
| BUREAU V. S. | | | |

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01242

CERTIFICATE OF DEATH

332

1240

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be submitted within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | MARYLAND LENGTH OF STAY (in this place) | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | COUNTY Somerset Princess Anne 19X02 (If rural give location) |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Peninsula General Hospital | STREET ADDRESS | Box 56 R.D. #2 |
| 3. NAME OF DECEASED (First) <i>xxxxxx</i> (Middle) <i>xxxxxx</i> (Last) | | 4. DATE OF DEATH <i>January 29 - 1957</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>Colored</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <i>January 27, 1957</i> |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME <i>Mary Stewart</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| <i>760.0 IMMEDIATE CAUSE (A) Respiratory Failure</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO <i>Cerebral edema and atelectasis.</i> | | | |
| DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Intracutaneous Anoxia</i> | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO <i>Prolonged labor + sepsis of Mother</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19e. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) <i>Salisbury</i> (State) <i>Md.</i> | | 21d. TIME OF INJURY (Month) <i>Jan</i> (Day) <i>29</i> (Year) <i>1957</i> (Hour) <i>6</i> AM | |
| 21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>Jan 27, 1957</i> , to <i>Jan 29, 1957</i> , that I last saw the deceased alive on <i>Jan 27, 1957</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>William C. Morgan</i> M.D. ADDRESS (Street, city, town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>1/31/57</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>cremation</i> | | DATE THEREOF <i>1/31/57</i> | NAME OF CEMETERY OR CREMATORIAL <i>Peninsula General Hospital, Salisbury, Md.</i> LOCATION (City, town, or county) <i>Salisbury</i> (State) <i>Md.</i> |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i> | 25. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Morgan</i> ADDRESS <i>Peninsula General Hospital</i> |
| DATE <i>1-31-57</i> | | | |

2082161XV5

DEPARTMENT OF STATE - WASH. 25-1420

CERTIFICATE OF DEATH

RECORDED AND INDEXED - APRIL 10, 1957

APRIL 10, 1957

DEATH DATE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-510M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**1241 CERTIFICATE OF DEATH**

Reg. Dist. No. 11124332

| | | | | | |
|---|---|---|--|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN | MARYLAND LENGTH OF STAY (In this place) | STATE CITY (If outside corporate limits, write RURAL end give nearest town) TOWN | COUNTY SUSSEX STREET ADDRESS | | |
| Wicomico SALISBURY | 3 weeks | Delaware DeLMAR. | 116X3 R7D#2 | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | Peninsula General Hospital | | | | |
| 3. NAME OF DECEASED (Type or Print) | (First) Joseph R | (Middle) | (Last) Stokes. | | |
| S. SEX MALE | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH 9-6-1904 | 9. AGE last birthday 52 yrs. | 4. DATE OF DEATH JANUARY 5 th 1957. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXTERMINATOR | | 10b. KIND OF BUSINESS OR INDUSTRY RODENT | 11. BIRTHPLACE (State or foreign country) CUMBERLAND - MD | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME JOSEPH H. STOKES | | 14. MOTHER'S MAIDEN NAME MARGARET RICKNOR | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO | | 16. SOCIAL SECURITY NO. 165-07-5470 | | 17. INFORMANT & ADDRESS MARIE STOKES - DELMAR-DEL | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | |
| 451X IMMEDIATE CAUSE (A) Hemorrhage both pleural cavities 2 days ANTECEDENT CAUSE(S) DUE TO Rupture of dissecting Aortic Aneurysm | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) Atherosclerosis of Aorta | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Coronary Artery Heart Disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... P.M., from the causes and on the date stated above. | | | | | |
| SIGNATURE <i>James J. Holloway</i> M.D. ADDRESS (Street, city, town, state) <i>Salisbury, Md.</i> DATE SIGNED <i>Jan 5, 1957</i> | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | DATE THEREOF 1-9-1957 | | NAME OF CEMETERY OR CREMATORIUM MT. OLIVE | |
| 24. REC'D BY REGISTRAR DATE JAN 11 1957 | | REGISTRAR'S SIGNATURE Mary W. Holloway | | LOCATION (City, town, or county) DELMAR- DEL. ADDRESS W. S. Panel Co - Delmar, Del | |
| 25. FUNERAL DIRECTOR'S SIGNATURE | | | | | |

RECEIVED - STATE DEPARTMENT OF HEALTH-SANITATION

150 - CERTIFICATE OF DEATH

RECEIVED - STATE DEPARTMENT OF HEALTH-SANITATION

BUREAU V. S.

JAN 11 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 455 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

011244

332

CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|--|-----------------------------------|--|------------------------------------|---|------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Wicomico</u> | | MARYLAND | | STATE <u>VIRGINIA</u> COUNTY <u>Accomack</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Salisbury</u> | | | | TOWN <u>HORTON TOWN</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | | | STREET ADDRESS <u>83x-3</u> | | (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) <u>Baby Boy</u> | | | | 4. DATE OF DEATH <u>JANUARY 3 1957</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Newborn</u> | 8. DATE OF BIRTH <u>JANUARY 2</u> | 9. AGE last birthday yrs. <u>0</u> | IF UNDER 1 YEAR Months <u>0</u> | IF UNDER 24 HRS. Days <u>0</u> | Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Earl Strautz</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katherine Justice</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 762.5 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO | | (A) <u>Atelectasis, congenital</u> | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | (B) <u>Cerebral anoxia</u> | | | | | |
| | | (C) <u>Prematurity (Birth wt 2 lbs)</u> | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) <u>White Oak</u> | | (County) <u>Oxford</u> (State) <u>MD</u> | |
| 21d. TIME OF INJURY (Month) <u>1/2</u> (Day) <u>13</u> (Year) <u>1957</u> (Hour) <u>2:40 AM</u> | | 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Fallen from bed</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>1/2 1957</u> to <u>1/3 1957</u> , that I last saw the deceased alive on <u>1/3 1957</u> , and that death occurred at <u>2:40 AM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>John Bandaloski Jr</u> DATE SIGNED <u>1/3/57</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1-5-67</u> | | NAME OF CEMETERY OR CREMATORIAL <u>Downing</u> | | LOCATION (City, town, or county) <u>Oak Hill</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Maryell Holloway</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salter</u> | | ADDRESS <u>Christiansburg, Va.</u> | |
| DATE <u>1-12-57</u> | | | | | | | |
| 2082261XVO | | | | | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1243 CERTIFICATE OF DEATH

01245

332

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY WicomicoCITY (If outside corporate limits, write RURAL
OR end give nearest town)TOWN SalisburyHOSPITAL OR
INSTITUTION OR
STREET ADDRESSPeninsula General Hospital

MARYLAND

LENGTH OF STAY
(In this place)2 Mo

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MdCOUNTY Maryland

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWNSTREET
ADDRESS23X02

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)Robert W.

(First) (Middle) (Last)

4. DATE (Month) (Day) (Year)

DATE
OF
DEATHJanuary 24 - 1957

5. SEX

6. COLOR OR
RACE10b. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
part-time)10c. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

William C. Sturgis

14. MOTHER'S MAIDEN NAME

Anna E. Cooper12. CITIZEN OF WHAT
COUNTRY?15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or blank) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

20. AUTOPSY?
YES NO IMMEDIATE CAUSE (A) Cerebral ThrombosisANTECEDENT CAUSE(S) DUE TO Cerebral Arteriosclerosis

DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. DUE TO (C) Myocardial InsufficiencyII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Gangrene + cellulitis left legINTERVAL BETWEEN ONSET AND DEATH 2 days

19e. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/4/1956, to 1-24-1957, that I last saw the deceased alive on 12/31/1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above.SIGNATURE Xavier J. BelmoreADDRESS (Street, city, town, state) Salisbury MdDATE SIGNED Jan. 24, 195723. BURIAL, CREMATION,
REMOVAL (SPECIMEN) DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)

24. REC'D BY REGISTRAR JAN 28 1957 REGISTRAR'S SIGNATURE MARY J. HOLLOWAY, MARY B. DENNIS, ADDRESS SNOW HILL, MD

RECEIVED BY THE STATE OF MARYLAND

CERTIFICATE OF DEATH

DEATH CERTIFICATE

ISSUED TO JOHN WILSON, JR.

DEATH CERTIFICATE

DEATH CERTIFICATE

DEATH CERTIFICATE

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1244

CERTIFICATE OF DEATH

Reg. Dist. No. 112487

| | | | | | | | | | |
|--|--|---|---|---|---------------------------------------|---|---------------------|---------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 12 | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | d. STREET ADDRESS 1 Calvert St | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First GEORGE | Middle NATHANIEL | Last VETRA | 4. DATE OF DEATH JANUARY 31st 1957 | Month JANUARY | Day 31st | Year 1957 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 12, 1887 | 9. AGE (In years lost birthday) 69 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 | Hours 0 | Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Painter | | 10b. KIND OF BUSINESS OR INDUSTRY Painting | | 11. BIRTHPLACE (State or foreign country) Deal Island, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME George N. Vetra | | 14. MOTHER'S MAIDEN NAME Ella L. Lawrence | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | 16. SOCIAL SECURITY NO. W.W. I | 17. INFORMANT Mr. Nelson D. Vetra (Son) 411 Virginia Ave. Salisbury, Maryland | Address | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung | | | | | | | | | |
| 169X DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) | | | | | | | | | |
| DUE TO | | | | | | | | | |
| (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | Day | 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) 131 | (County) | (State) | | |
| 21. I certify that I attended the deceased from 12/29 , 1957, to 1/31 , 1957, that I last saw the deceased alive on 1/31 , 1957, and that death occurred at 11:00 P.M. from the causes and on the date stated above. | | | | | | | | | |
| ADDRESS (Street, city or town, state) S. Division St. (Office) | | | | | | | | | |
| DATE SIGNED Feb. 1st 1957 | | | | | | | | | |
| ACTUAL SIGNATURE Fred R. Gramse | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse M.D. | | | | | | | | | |
| Salisbury, Maryland | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Feb. 3, 1957 | 22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery | 22d. LOCATION (City, town, or county) Salisbury, Maryland | (State) | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | | | | | | | | |
| ADDRESS FE 24 1957 | | | | | | | | | |
| 24a. REC'D BY REGISTRAR Mary H. Holloway | | | | | | | | | |
| 24b. REGISTRAR'S SIGNATURE | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | |
|--|----------------|----------------|
| DECEASED'S NAME | AGE | SEX |
| EDWARD J. KELLY | 62 | MALE |
| ADDRESS | STREET | CITY |
| 101 E. BELMONT | BALTIMORE | MARYLAND |
| NAME AND ADDRESS OF DOCTOR | STREET | CITY |
| DR. JAMES F. DUNN 101 E. BELMONT | BALTIMORE | MARYLAND |
| NAME AND ADDRESS OF FUNERAL DIRECTOR | STREET | CITY |
| WILLIAM H. COOPER 101 E. BELMONT | BALTIMORE | MARYLAND |
| TIME OF DEATH | DATE OF DEATH | CAUSE OF DEATH |
| 10:30 A.M. | APRIL 10, 1957 | HEART DISEASE |
| I declare under penalty of perjury that the above information is true and correct. | | |
| SIGNED: EDWARD J. KELLY | | |
| APPROVED: DR. JAMES F. DUNN | | |
| APPROVED: WILLIAM H. COOPER | | |

BUREAU V. S.

EEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01247
337

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury | |
| 3. NAME OF DECEASED (Type or print) First OLIVER (OLIE) SHAW | | Middle WALLER | Last WALLER |
| 4. DATE OF DEATH January 28th | | Month January | Doy 28 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH Sept. 8, 1898 | | 9. AGE (In years lost birthday) 58 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian-N. Salisbury Elementary Public School | | 10b. KIND OF BUSINESS OR INDUSTRY Laurel Delaware | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME George E. Waller | | 14. MOTHER'S MAIDEN NAME Lettie Oiphant | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk | | 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Roxie G. Waller (Wife) 210 Marshall St. Address Salisbury, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) | | | |
| DUE TO Due to (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1-6, 1957, to 1-28, 1957, that I last saw the deceased alive on 1-28, 1957, and that death occurred at 11:25 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. Eugene J. Linberg M.D. Medical Center Jan. 29 1957 PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 31, 1957 | 22c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park |
| 22d. LOCATION (City, town, or county) Salisbury, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | 24a. REC'D BY REGISTRAR DATE JAN 30 1957 | 24b. REGISTRAR'S SIGNATURE Mary H. Holloway |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be retained by the hospital or attending physician. If this certificate is to be used as the burial-transit permit, then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU U.S.

JAN 30 1957

RECEIVED
MAY 20 1957

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01248

1246 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH

COUNTY Wicomico
CITY (If outside corporate limits, write RURAL
OR end give nearest town)
TOWN Salisbury

MARYLAND

LENGTH OF STAY
(In this place)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY SOMERSETCITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Pocomoke, MdSTREET ADDRESS
(If rural give location)19x02 RT. 1 Box 543. NAME OF
DECEASED
(Type or Print)(First) Nancy

(Middle)

(Last)

Waters

4. DATE (Month) (Day) (Year)

OF
DEATHJanuary 9 1957

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)DOMESTIC10b. KIND OF BUSINESS
OR INDUSTRYHousewife

13. FATHER'S NAME

Jacob Holland

14. MOTHER'S MAIDEN NAME

Sincia Wright15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) No 16. SOCIAL SECURITY NO.

(If Yes, give war or dates of service)

17. INFORMANT & ADDRESS

Alzonia Waters - Pocomoke, Md.INTERVAL BETWEEN
ONSET AND DEATH

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

572.1 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. (C)

RECEIVED
FEB 17 1957
U.S. GOVERNMENT PRINTING OFFICE: 1957 100-1000

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01249332

| | | | | | | | | | | | |
|---|--|---|--|--|---|--|-----------------------------|-------------|------|---------|--|
| 1247 | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Salisbury | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | d. STREET ADDRESS R.D.# 3 (Delmar Rd) | | | | | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNK | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) GEORGE | | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH June 25, 1883 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months 6 | IF UNDER 24 HRS. Days 16 | Hours | Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Clinton, N. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | |
| 13. FATHER'S NAME XXXX George West | | 14. MOTHER'S MAIDEN NAME Rebecca McLemb | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Clarence G. West (Son) R.D. #3 (Delmar Rd) Salisbury, Maryland | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>1/14/57</u> , 19, to <u>1/14/57</u> , 19, that I last saw the deceased alive on <u>1/14/57</u> , 19, and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) | | | | | | | | | |
| ACTUAL SIGNATURE Dr. Fred R. Gramse | | M.D. | | S. Division St. | | (Office) | | DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse | | Jan. 12, 1957 | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 15, 1957 | | 22c. NAME OF CEMETERY OR CREMATORIUM Fayetteville Cemetery | | 22d. LOCATION (City, town, or county) Fayetteville, N. Carolina | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME-SALISBURY, MD. | | 24a. REC'D BY REGISTRAR DATE JAN 11 1957 24b. REGISTRAR'S SIGNATURE Mary J. Holloway | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8:3000MT148-MT2A8F9C 75314724980 STATE-QM147988

BUREAU V. S.

IAN 14 1957

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01253

Reg. Dist. No. 332

| | | | | | | | |
|---|--|------------------------------------|--|--|--|--------------------|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs | | c. LENGTH OF STAY IN 1b 7 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wallertown | | d. STREET ADDRESS Wallertown | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |

| | | | | | | | |
|--|-----------------------------|---|--------------------------------------|--|--------------------------|--|---------------|
| 3. NAME OF DECEASED (Type or print) | First James | Middle Shelley | Last Wright | 4. DATE OF DEATH January 6 1957 | Month January | Day 6 | Year 1957 |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH February 7, 1899 | 9. AGE (In years last birthday) 57 yrs. | IF UNDER 1YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (State or foreign country) Somerset County, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joshua Black | | 14. MOTHER'S MAIDEN NAME Jane Washington | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Mrs. Annie D. Wright, Mardela Springs, Md. | | Address | |

| | | |
|---|--|----------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | Sudden |
| 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic heart disease</u> | | Years |
| DUE TO (c) | | |

| | | |
|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|--|--|---|

| | | | |
|--|------------------------|---|---|
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State) |

| | | | | | |
|--|--|--|--|--|--|
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
|--|--|--|--|--|--|

| | | |
|--|--|-----------------------|
| ACTUAL SIGNATURE <i>Earl L. Royer</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | DATE SIGNED 1-8-57 |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | |

| | | | |
|---|-----------------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Jan. 9, 1957 | 22c. NAME OF CEMETERY OR CREMATORIUM Green Acres Cemetery | 22d. LOCATION (City, town, or county) (State) Near Salisbury, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland | | ADDRESS J.J. Frampton and Son, Federalsburg, Maryland | 24a. REC'D BY REGISTRAR DATE 1-10-57 |
| | | | 24b. REGISTRAR'S SIGNATURE Maryell Holloway |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

REGISTRATION STATEMENT OF NEW SECURITY
NATIONAL EXAMINER & CERTIFICATE OF DEATH

BUREAU V. S.

IAN 14 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01250

CERTIFICATE OF DEATH

Reg. Dist. No. 338

1248

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | MARYLAND LENGTH OF STAY (In this place) | STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | COUNTY SALISBURY (If rural give location) |
| Wicomico SALISBURY | 9 days | XO 1 | MARYLAND SALISBURY ROUTE 5 |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | PENINSULA GENERAL HOSPITAL | | |
| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) |
| Fletcher | | | White |
| 4. DATE OF DEATH | (Month) | (Day) | (Year) |
| | JAN | 31 | 1957 |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH |
| III | A.H. | SINGLE | ABOUT 1868 |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| LABORER | | FARMING | UNKNOWN |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Unknown | | Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | |
| No | | NONE | |
| 17. INFORMANT & ADDRESS | | 18. MEDICAL CERTIFICATION | |
| TWIN LAKES Mr. Daniels - SALISBURY, MD | | Coronary Occlusion Arteriosclerosis Chronic Nephritis Kidney Stone Mephistothaeus | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 1.5 hours | | | |
| ? | | | |
| ? | | | |
| ? | | | |
| ? | | | |
| 19e. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21e. INJURY OCCURRED M. While at work | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from Jan 22, 1957, to Jan 31, 1957, that I last saw the deceased alive on Jan 21, 1957, and that death occurred at 10:30 P.M. from the causes and on the date stated above. SIGNATURE G. Herbert Hembly, M.D. | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 2-5-57 | |
| | | NAME OF CEMETERY OR CREMATORIUM GREEN ACRES MEMORIAL PARK | |
| 24. REC'D BY REGISTRAR FEB 5 1957 | | REGISTRAR'S SIGNATURE Mary H. Hembly | |
| | | LOCATION (City, town, or county) Salisbury, Md | |
| | | 25. FUNERAL DIRECTOR'S SIGNATURE F. Stewart Funeral Home | |
| | | ADDRESS Salisbury, Md | |

RECEIVED - DEPARTMENT OF STATE - WASH. D. C.

CERTIFICATE OF DEATH

DEATH CERTIFICATE

BUREAU Y.

FEB 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1249

CERTIFICATE OF DEATH

012531

Reg. Dist. No.

1. PLACE OF DEATH

a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

702 Smith St

3. NAME OF DECEASED
(Type or print)First
LILLIEMiddle
A.Last
WHITE4. DATE
OF
DEATHMonth
JANUARYDay
7th
Year
19 57

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

October 14, 1871

9. AGE (In years last birthday)

85 yrs.

IF UNDER 1 YEAR

2 Months

IF UNDER 24 HRS.

23 Days

Hours

57 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Work

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Kenton, Delaware

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Nathaniel Riggs

14. MOTHER'S MAIDEN NAME

Anna Hillyard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. G. Reynolds White (Son) 702 Smith St.
Address
Salisbury, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

450.0

DUE TO

coronary Insufficiency

INTERVAL BETWEEN
ONSET AND DEATH

4 weeks

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause first.

(b)

DUE TO

Arterio sclerotic Heart Disease

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. s. 19
p. m.20d. INJURY OCCURRED
While Nat while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County)

(State)

21. I certify that I attended the deceased from

1946, to 1957, that I last saw the deceased

alive on 1/1/57

19, and that death occurred at 7:00 P.M. from the causes and on the date stated above.

ACTUAL
SIGNATURE

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S
NAME (Type)

Dr. Fred R. Gramse M.D.

Salisbury, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial22b. DATE THEREOF
Jan. 9, 195722c. NAME OF CEMETERY OR CREMATORIUM
Parsons Cemetery22d. LOCATION (City, town, or county)
(State)
Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD.

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

JAN 9 1957 Mary J. Holloway

BUREAU V. S.

JAN 9 1957

RECEIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be retained by the funeral director. Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1250

CERTIFICATE OF DEATH

01252

332

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital | | d. STREET ADDRESS Schumaker Rd | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Unk | | | |
| 3. NAME OF DECEASED (Type or print) First MARION Middle SLEMONS Last WILSON | | 4. DATE OF DEATH JANUARY 11 th 1957 | |
| 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | 8. DATE OF BIRTH October 21, 1902 | |
| 9. AGE (In years last birthday) 54 yrs. | | 10. IF UNDER 1 YEAR 2 Months 20 Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 10c. BIRTHPLACE (State or foreign country) Salisbury, Maryland | | 11. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Wilson | | 14. MOTHER'S MAIDEN NAME Lavenia Hastings | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk | | 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Lula E. Walls (Sister) 39 Maple St. Address Marcus Hook, Pa. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 DUE TO Electrolyte imbalance with shock INTERVAL BETWEEN ONSET AND DEATH | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Intestinal obstruction DUE TO | | | |
| } (c) Vascular accident | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 434 Chronic heart disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10 Jan. 1956, to 11 Jun. 1956, that I last saw the deceased alive on 11 June 1956, and that death occurred at 3:10 P.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE Eugene J. Linberg M.D. | | Medical Center Jan. 12 1957 | |
| PHYSICIAN'S NAME (Type) Dr. Eugene J. Linberg | | M.D. Salisbury, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Jan. 13, 1957 22c. NAME OF CEMETERY OR CREMATORIUM Parsons Cemetery 22d. LOCATION (City, town, or county) (State) Salisbury, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME - SALISBURY, MD. | | ADDRESS 24a. REC'D BY REGISTRAR DATE JAN 14 1957 24b. REGISTRAR'S SIGNATURE Mary H. Holloway | |

BUREAU V.

1957 14 N

THE GENEVA